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Pastoral care of nervous
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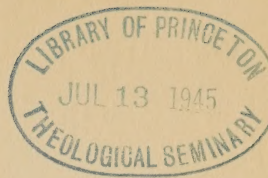
Pastoral Care of Nervous People

PASTORAL CARE
of
NERVOUS PEOPLE

AN ELEMENTARY HANDBOOK

By
HENRY JEROME SIMPSON

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Foreword

THE WRITER OF THIS BOOK IS A CLERGYMAN WHO HAS been confronted, as all clergymen have, with individual and mass difficulties in the functioning of the lives of his parishioners. The conscientious clergyman, Protestant or Roman Catholic, has always had to face these issues. From time immemorial he has tried to meet the maladjustments of his flock as matters which could and should be solved with principles of indoctrination that embodied the issues of right or wrong. As time went on the clergy came to realize that men differ so much in their intellectual and personality and biological capacities that they cannot be expected to be helped when told about right and wrong. Clergy also began to realize that many complaints of bodily ailings without physical basis were not self-centered whinings and lamentations but represented psychological abnormalities of emotions and thinking with which these people needed scientific help and understanding. That unfortunate rift between religion and science began to be closed. Clergy came to realize that their work with the spiritual ingredients of man and the work of psychologist and psychiatrist were not so far apart; that doctor and clergy are working with the same human being, each contributing his own helpful-

ness; that fears and obsessions and the like are expressions of human activities which have a biological and psychobiological basis beginning in childhood, accentuated by environment, and constituting inherent weaknesses, the rehabilitation of which embodies something more than concepts of sin. As a result of this mutual awakening clergy have come to read and investigate the fields of psychology and psychiatry, and psychiatrists have become aware of the spiritual values in the lives of the patients with whom they work. As a result we have many theological seminaries today—Roman Catholic and Protestant—sending their students for periods of study into psychiatric hospitals and institutes to learn the intricacies of the mentally sick and emotionally unstable.

The Rev. Mr. Simpson's book attempts to present some viewpoints of various schools of psychiatric thought and their methods of approach to understanding the psychological background of various states of poor mental health that come to the notice of clergyman and doctor. This little book is well worth reading by clergy and doctors as an honest effort to afford each an opportunity to know about the work that the other is trying to do. It is not a scientific treatise. It is not a theological treatise. It is a simple, straightforward effort to integrate the efforts of each toward a better evaluation of their respective provinces in human helpfulness.

—*Esther Loring Richards, M.D.,*
The Johns Hopkins University.

PREFACE

DR. ADOLF MEYER ONCE WROTE ME, SPEAKING OF THE fields of religion and psychiatry, "It seems to me an important task to build bridges between the many kinds of consumers and what we would like to make available." That was not said in relation to this book, though the book has been written with the idea of making it such a bridge. There is so much in psychiatry, as there is in psychology, which the faithful pastor ought to know, and religion can be such a help to the psychiatrist, that there should be an *entente* between the two subjects. Too often each field is entirely unknown to the other. And the need for putting pastoral work on something of a scientific basis, if such ministry is to be of real value in the years to come, is as clearly indicated as the need for medicine and psychiatry to be supplemented and completed by religion. Thus it is to provide an elementary introduction to the scientific approach to pastoral work that this book is written.

Such a book as this cannot provide an exhaustive presentation of religion and all its mores. The varieties in religion are countless. The differences between conservative and liberal thought, the teachings of the different Churches, the varieties of religious experience, and the conflicting con-

cepts of the Bible and its interpretation—all would require an encyclopedia. The aim in this book is to express religion in its simplest terms, to give only its major essentials.

In the same way this book cannot be a treatise on medicine, neurology, or psychiatry. Nor can it give a full clinical picture of the various forms of nervous disorders. The psychopathology of nervous conditions may be found in many valuable books, a few titles of which are given in the bibliography. Such works should be studied carefully by every clergyman who attempts the pastoral treatment of nervous disorders. Only so can he avoid the wishful thinking and the guesswork of uninformed “healing” so often practised by ministers, or the impression of psychiatry he gains from reading a little of Freud. For too many of the clergy *psychiatry* is another word for *psychoanalysis*.

The chief thing attempted here is to bring out the point of contact between religion and a scientific approach to a good adjustment to life. The problem has been limited and defined in order to show where the minister has a real function and where he must not trespass on the field of the physician or the psychiatrist. Therein lies the great danger of “spiritual healing.” The pastor must limit his work to the minor neuroses, though that group is a very large one and there are not enough psychiatrists or psychiatrically-trained physicians to deal with it. Using religion as a pre-

ventative and therapeutic agency, the minister has, within his limitations, a great work to do.

It may very well be possible in the future for ministers who do this work to have clinical training under psychiatrists. A few months in a psychopathic hospital, in contact with patients who are the victims of the major psychoses, is, however, of questionable value to the pastor.

And the opportunities to study the minor neuroses under a trained psychiatrist are hard to find. Until such opportunities are offered to ministers they must depend upon their own study and their pastoral experience. Such pastoral work should have the same value as that of the physician who is a man of God and who is able, by his well-placed religious counsels, to add real religious help to his medical services. The clergy are always heartened to find such physicians of the soul as well as of the body. Would that there were many more of them!

—H.J.S.

St. Peter's Church
Detroit

ACKNOWLEDGMENTS

MY GREAT GRATITUDE IS DUE TO THOSE DISTRESSED souls who in past years have given me the opportunity to help them rebuild their lives on better foundations. I feel I owe everything I may have learned in psychiatry to Dr. Adolf Meyer of Johns Hopkins, who, though he has written no books, has found expression through his pupils' books. I owe more than I can say to Dr. Edward G. Billings, professor of psychiatry in the Colorado School of Medicine and a pupil of Dr. Meyer, for his reading of the manuscript of this book and for his many corrections and suggestions.

My good bishop, the Rt. Rev. Frank W. Creighton, has most kindly read the manuscript and given me excellent suggestions and his encouragement. Dr. Edward M. Cowles has been helpful through his friendship and by the example of the great work he has done at the Body and Mind Clinic in New York. I am grateful also to Dr. Henry A. Luce, Detroit psychiatrist, who has read through the manuscript and been helpful in many ways. And finally I deeply value the loyalty of the good people of St. Peter's Church in yielding to me the time necessary for work with nervous people through our Clinic for Personal Adjustment.

—H.J.S.

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Pastoral Care of Nervous People

1

Introduction

I. The Plight of the Psychoneurotic

THE VICTIMS OF NERVOUS DISORDERS COMMONLY called *neuroses* or *psychoneuroses* are the real forgotten men and women of the world. A person blighted by such a condition is too often looked upon by his family as "selfish," "cussed," "ornery," or "just a little bit crazy." He is charged with bringing his condition upon himself, and it is suggested that, if he would, he could "forget it" and "snap out of it." Harsh words, whispered remarks, and furtive looks are his lot, and when he attempts to read or think himself out of his misery he finds himself slipping deeper and deeper into the quicksands of neuroticism. Dr. Myerson, in his popularly-written *Psychology of Mental Disorders*, says of such a person: "Misunderstood by his family, and their despair, this poor psychoneurotic wanders from doctor to doctor, and each specialist takes a whack at him. His tonsils are removed, his teeth pulled, his arches supported, his back strapped, and if he happens to be a 'she' her inner organs are in grave danger."¹ Such a person is not good company because he is always talking about his "condition." He is shunned as a bore and treated as a nuisance.

¹ Myerson, Abraham, *Psychology of Mental Disorders*, p. 58, New York: Macmillan. Used by permission.

As a result, he withdraws from normal life, retires with his morbid thoughts into lonely fearfulness, and his neurosis grows deeper and more terrifying. Though Isaiah was speaking (Chapter 42:22) of the Children of Israel and how they failed God and were punished for it, the words fit the case of the psychoneurotic: "This is a people robbed and spoiled; they are all of them . . . hid in prison houses: they are for a prey, and none delivereth; for a spoil, and none saith, Restore."

Such a nervous condition does not continue long until the sufferer goes or is taken to a physician. The physician should of course be consulted, for many neurotic ailments are the results of bodily disorders which need the physician's care. Others, however, are caused by conditions not physical, and in these cases physical examinations will yield only negative results. Too often then the family physician will recognize the neurotic condition but, having neither the time nor the training to deal with it, will tell the patient that it is "nothing but nervousness" and that he "should go home and forget it." Or he may tell the patient he is having or is on the verge of having a "nervous breakdown"—a phrase which sounds ominously like "going insane" to the patient and which frightens him into a deeper neurotic state. The doctor may give him a placebo, try to cheer him on the basis of the good old *vis medicatrix naturae*, or prescribe one of the many sedatives available. Such treatment does not help the psychoneurotic. It sends

him home worse than when he came, for he may have picked up an amazing number of new things to worry about. If he has a nervous heart, for instance, the doctor may frighten him by a serious manner and a grave warning that he "may develop a serious heart condition if he is not careful." One psychoneurotic whom the writer sent to a physician for a careful check-up received the check-up and also two medicines. On inquiry, the physician admitted the young man was in good condition, physically, but added that "he would not have known he had gone to a doctor if I had not given him some medicine." The medicine, of course, confirmed the young man in his belief in his physical complaints. It is understandable why such patients shop around from one doctor's office to another in the vain hope of getting help. Medical authorities have shown that the physician who, over a period of time, treats a psychoneurotic as outlined here, and does not refer him to a psychiatrist, actually spend three or four times more hours than would be necessary to elicit the whole story and give common sense advice and guidance.

It is understandable why these people, who make up a good percentage of a doctor's office patients, are so great a problem to him. As has been said, the physician does not always have time to give to these patients. Both the study and the treatment of the neurotic take many hours of quiet, thoughtful interviews, and this is impossible for many busy practising physicians. In the second place, the

family doctor, in the past, has not had the training to treat psychoneurotics. He may have had a course in psychiatry and some experience in a psychopathic hospital, but these have not necessarily trained him to deal with the psychoneuroses. The psychiatrist has had training in treating neurotics; but the older men in the profession are often occupied with major psychopathic conditions. This is not so with the younger men. During the past ten years medical schools have put forth tremendous efforts to prepare graduates to handle these problems. Experience and critical studies indicate that many younger graduates, although not capable of successfully treating the psychoneurotic of long standing, are in an increasing number of instances able to correct early reactions of this type. This is really the field of mental hygiene. It is, of course, only in the larger population centers that psychiatrists are to be found, and they are beyond the reach of a vast part of the population. When, then, a neurotic person goes to a number of practising physicians without getting help, in case he is unable to have the aid of a psychiatrist, he is like the woman in St. Mark's gospel (5:26) who "had suffered many things of many physicians, and had spent all that she had, and was nothing bettered, but rather grew worse." The name of such sufferers is legion.

It must be said that there are many institutions where help can be secured if the patient can afford it or if he knows of these means of help. Dr. E. M.

Cowles in the Body and Mind Clinic in New York, Dr. A. B. Olsen, formerly at the Battle Creek Sanitarium in Michigan, and the well-trained younger psychiatrists and their teachers in many great hospitals throughout the land are oases in the desert. But these exceptional institutions and individuals are not able to meet the needs of the huge army of psychoneurotics who need help, for sooner or later nervous disorders of this sort plague most people to greater or less extent.

II. The Pastor and the Psychoneurotic

There must be help for these troubled people. The pastor is in a unique position to deal with them. He should be, as pastor, a specialist in dealing with personality problems and disorders; he is, or should be, an educated man capable of familiarizing himself with the literature of the subject, for whether it lies in the field of child training, psychology, or psychiatry, such knowledge as he needs for the intelligent ministering to his people belongs to him if he will study it. If the pastor is to administer adequately to nervous patients, he must have, in addition to a working religion with its transforming power, a knowledge of normal personality development and functioning, general psychology, psychiatry or the science having to do with abnormal personality reactions, and at least a realization of some of the many medical and neurological disorders that might be of causative importance.

There is nothing esoteric about these studies, and it is the pastor's right and duty to familiarize himself with them before he attempts to deal with psychoneurotics. It is past the time that careful courses in these subjects should have been given in the seminaries if the pastoral office is to be taken seriously in this age.

The question as to whether the non-medically trained person should enter the field of psychoneuroses must be considered. Many practising physicians feel that anything concerning health is their province, though the development of specializations is rapidly changing that idea. The problems of the psychoneurotic which lie in the fields of the physician, the neurologist, or the psychiatrist must of course be treated by these specialists. In so far as the psychoneurotic presents problems which are basically psychological, moral, or religious, or are problems of morale, the minister is in position to help. Questions concerning mental habits, emotional life, home training or the lack of it, the ideals, the aims and purposes of life, fears, anxieties, confusion over the meaning of life and religion—all these come within the field of pastoral work. Freud saw no obstacle in the way of those who did not have medical education practising psychoanalysis, though while Freud was still living the American and International Psychoanalytic Societies decided otherwise. Dr. Edward G. Billings wrote, in speaking of the compulsive-ruminative-tension states, the most serious form of the psychoneuroses (if

they are psychoneuroses): "in contradistinction to some of the other disorders of personality [these] are therapeutic problems for the psychiatric specialist."² This might indicate that minor neuroses may be treated by other qualified persons even though they are not psychiatrists.

Not every pastor is adapted to this form of ministry. It should be left to those who have natural pastoral gifts, who are students and will continue to be students—men endowed with patience, sympathetic personality, common sense, and a sound religious experience.

When pastors are properly qualified to undertake this work with psychoneurotics, it should be possible to secure such co-operation with physicians as is granted to nurses and masseurs. When one recalls the long bitter struggle every new departure from orthodox medicine underwent before it was accepted as sound, he may be patient and look forward to better days to come. The minister should be the last to complain of orthodoxy and conservatism! The proper education of the pastor is the one thing needful, and when this is accomplished relations with medical men will take care of themselves. Even the physician skilled in psychiatry and medicine, as will be pointed out, often encounters great difficulty in distinguishing between psychogenic and organogenic disorders. For the pastor to attempt to treat these minor

² Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*, p. 133, New York: Macmillan. Used by permission.

reaction types without medical council is, therefore, both stupid and dangerous. He must either have the co-operation of a well-trained and understanding physician or run the risk of jeopardizing his "patient" and his own reputation.

III. Varieties of Approach to the Problem

He who would work with psychoneurotics must come to terms with recent advances in the knowledge of these conditions and their treatment. The problem is complicated by wide differences between the many schools of thought concerning the "new psychologies." A glance at the background out of which they come will be of help.

In the 1880's new light was thrown on the one well-known form of nervous disorder, hysteria, by the use of suggestion and hypnotism. This grew out of the trail-breaking work of Dr. J. M. Charcot at Saltpêtrière where he carried on for many years a great work among the poorer classes of Paris. He summed up his convictions concerning the neuroses in his statement, quoted by DuBois, "The neuroses [he had hysteria in mind] arise from two factors; the one essential and invariable, neuropathic heredity; the other, contingent and polymorphic, the provoking agent."³ Charcot did much to advance both the theory and practise of the therapeutic use of hypnotism, though he did not

³ DuBois, Paul, *Psychic Treatment of Mental Disorders*, p. 440, New York: Funk and Wagnalls. Used by permission.

believe it would have any great value as a therapeutic measure. From Sweden to Italy physicians were carrying on experiments with hypnotism and with some success but with a growing sense of its limitations. Two physicians, Drs. E. Bernheim and A. A. Liébeault of Nancy, gave themselves to this investigation of hypnotism and probably did the best work. Wide interest brought about an entirely new approach to the subject of hysteria, because it revealed its cause as lying in the mental life of the patient rather than in mysterious and malignant forces. Charcot's contribution was outstanding.

At this same time two other young physicians, Siegmund Freud and Paul DuBois, were interesting themselves in the study of nervous condition. Both of them turned away from the use of hypnotism to the search for mental causes. Dr. Freud had studied under an old Viennese physician, Dr. Josef Breuer, and it was an unusual case of Dr. Breuer's which provided the key to all that later came to be known as psychoanalysis—the strange case of a young woman with hysteria whom Dr. Breuer was unable to cure by hypnotism but was able to cure by discovering the incidents which caused her condition and explaining them all to her in repeated conversations. The patient herself called it the “talking cure,” and Dr. Breuer named it the cathartic method. Dr. Breuer did not attribute any particular value to this new method he had discovered, but Freud did, and in his later work frankly gave Dr. Breuer full credit for the discovery. Fol-

lowing Dr. Breuer, Freud called the method that of "catharsis."

The other young physician who at this time was making his own study of hysteria and other nervous disorders was Dr. Paul DuBois of Berne, Switzerland. Like Dr. Charcot he was never inclined to favor the use of hypnotism, and after a day spent at Nancy with Dr. Bernheim he made his final decision against it and gave himself to his own approach to the problem. His plan was to make a thorough survey of the patient and provide whatever medical care might be necessary, as well as to make a careful mental and nervous study. His treatment has been called that of "persuasion," and consists in giving the patient a brief statement concerning his condition and showing him the way to a better mental attitude. For twenty years he did an outstanding work at Berne before he wrote his book, *The Psychic Treatment of Nervous Disorders*. He left no organized group of followers, but he bequeathed to the world a common-sense approach to the problem of the psychoneuroses.

A. Freud and Psychoanalysis: Freud's chief interest was in psychology and in searching for the causes and treatment of nervous disorders in the psychological field. His beliefs were never static, for he was always honestly willing to change his mind. As the years passed and his books appeared, there is abundant evidence of his changing views. One wonders what would have resulted had he been given another ten or twenty years. His teach-

ings have been interpreted and misinterpreted by friends and enemies, while psychoanalysis as taught and practised by his interpreters has frequently been entirely at variance with Freud himself. Freud also has suffered from the commercialization and popularization of psychoanalysis.

Freud began with his theory of the unconscious. To him, the unconscious was a great storehouse of urges, desires, and memories which are repressed and often have been repressed since childhood in the interest of a satisfactory adjustment to society. When these repressed desires and ideas are successfully repressed, they remain in the unconscious as harmless thoughts or buried experiences, and life is blessed with a sense of well-being, courage, and faith. When, however, these repressed ideas threaten to escape into consciousness, there comes a feeling of anxiety, an ominous dread, or a sense of foreboding. Such a threatened breakdown of repression comes under the blows of frustration and disappointment. How this takes place and how repressed ideas find expression in neurotic symptoms coming out of various levels of the unconscious, the "social," the "narcissistic," the "organ erotic," or the "archaic," is well told by Dr. Jelliffe.⁴ Suffice it to say, this anxiety is a peculiarly distressing condition and the unconscious mind will go to strange lengths to ward it off. Its chief device is to substitute other conditions for the

⁴ Jelliffe, Smith Ely, *Technique of Psychoanalysis*, New York: Nervous and Mental Disease Monographs.

anxiety. These other conditions include every possible simulation of physical and mental disorder or disease. These become then the patient's neurotic symptoms. As Dr. Karin Stephen says in her first chapter, "neurotic symptoms are defenses designed to prevent anxiety from developing when repression threatens to give way."⁵ This process is entirely involuntary and the patient cannot be "blamed" for it.

Freud gives much thought to the contents of the unconscious. He finds that repressed desires and wishes which seek to break through into consciousness are constantly coming into conflict with the power of repression. He teaches also that such conflicts in the unconscious are associated there with other similar conflicts to form what is called a "complex." Freud says these complexes are "unconscious constellations of trends, ideas and emotions centered round a particular topic."

He goes yet further in identifying these repressed complexes as having their origin in some of the pleasurable sensations of the body. Such sensations are the desire for food and the pleasure of eating, the sensation of sucking, the desire for rest and for warmth, the pleasure of breathing, of using the voice, the relief of crying, and the sense of power which comes from anger. There is also the satisfaction of urination and of the expulsion of the feces, the special pleasure of certain "eroge-

⁵ Stephen, Karin, *Psychoanalysis and Medicine*, London: Cambridge Press.

nous zones'' of the body and particularly of the organs of sex. Freud chooses to classify all these bodily sensations of pleasure as "sexual," which explains the broad use of the word by psychoanalysts. To all such pleasurable desires—this restless energy—Freud has given the name of *libido*, and the various expressions of it he calls "partial libido trends."

Sex, as popularly understood, does enter Freud's teachings very prominently, however. He teaches that the most powerful and most common of all complexes is what he has called the "Oedipus complex"—from the old Greek myth of Oedipus who killed his father and unwittingly took his mother to wife. This "family drama," is re-enacted in most neurotic persons in some form and dominates the life of vast numbers of the entire population.

Freud calls repression the "main pillar" of his whole system of thought. There are various methods of repression. There is the method of refusing expression to the pent-up desires by a determined effort to keep them out of consciousness, a method which is exhausting and which has very definite limits in nervous persons. Another method is to allow pent-up desires to find their natural expression without restraint in an unsocial and sometimes an anti-social form of behavior. Another is that of "abreaction," by which a patient is brought to tell of his painful experience or desire without restraint or hinderance, and in this complete verbal expression find relief. The proper method of deal-

ing with complexes is to convert their energy into something socially good and useful, thus diverting the libido into desirable and economic channels.

The means of making this change is, in the language of Freud, the "transference." By this term he means the necessary co-operation between the patient and the psychoanalyst, the *rapprochement* without which it is of course impossible to cure a neurosis.

In psychoanalysis the first task is to search out the complex or complexes of the patient. This is done chiefly by what is known as "free association." By this procedure the patient is asked to let his thoughts and feelings roam as they will, not trying to direct or surpress them at all. He is to give expression to whatever he thinks or feels with promptness and fidelity, regardless of how painful or discreditable it may seem. In this extremely honest revealing of what is in the mind, the psychoanalyst will be able to determine what the complex or complexes are which have brought the psychoneurotic patient into his present impasse. It is a matter of being a good listener and a discreet questioner. Two-thirds of the treatment, as well as the analysis of the patient, is done by this free expression by the patient. Word association tests are also employed, as outlined in a later chapter. A great deal of stress is laid upon a study of the dreams of the patient, for Freud has given a good deal of attention to the meaning and symbolism of dreams, carrying the matter at times to fantastic lengths.

By the use of these methods the contents of that strange Pandora's box called the unconscious is studied and understood.

When the troublesome complexes are thus revealed, Freud resorts to the usual method of explaining them to the patient that the patient may see what has brought him into his neurotic state and how he must re-orientate his life in the future to be free from illnesses. He is led back in imagination and memory and lives over again the original experiences, to which he made wrong reactions, and now learns to react properly. There follows a period of re-education, or "sublimation," which continues until the patient is able to live as he should. This process may take from several months to several years. It is not easy for the analyst to search out and be sure of the exact problems in the case; it is much harder to get the patient to see it too and to remold his life accordingly. It is very largely a process of leading the patient to think himself out of wrong and into the right reactions to life.

Freud was a pioneer who merits full credit for all his trail-breaking work. One must recognize the fearless and single-minded devotion to the truth, as Freud saw it in the face of the scorn of the world, the hostility of much of the medical profession, and the falling away of his own disciples. He succeeded in bringing out the facts that neuroticism and perhaps even more serious mental disorders are the results, very frequently, of psychic causes; he pushed back the boundaries of scientific

knowledge of "the mind in disorder" as few have done; he gave the world a fresh study of the unconscious; he took sex out of the realm of the taboo and made it a matter of careful and objective study; and he saw the great importance of the early and even pre-natal years of life.

On the other hand there are serious weaknesses in Freud's system of thought. Among these are:

(1) A good many psychiatrists feel Freud's teachings grew out of his own reasoning processes rather than clinical study. One psychiatrist wrote recently: "thus the teachings of infantile sexuality and the Oedipus complex were not derived from the study of children but willfully bestowed upon them *a priori*."⁶

(2) He has placed too great stress upon the sex instinct to the serious neglect of other instincts and urges.

(3) He teaches that deep down in the heart of mankind there is a devil, the Oedipus complex, together with all the dark malignity of the unconscious, rather than the presence of the spirit of God. In his later writings, particularly in his last book, he made it clear that religion belongs to the sphere of witches that peep and mutter. He had no adequate understanding of religion.

(4) In their clinical aspects, according to a good many psychiatrists, Freud's methods prove no higher percentages of cures than other methods, if

⁶ Kanner, Leo, *Child Psychiatry*, p. 7, Springfield: C. C. Thomas. Used by permission.

as high, while the time of treatment may extend into years and terminate in failure.

(5) Psychoanalysis is applicable to only a few of the many personality difficulties; it is a highly technical procedure requiring years of study and training, and when incorrectly used it is, or can be, extremely dangerous.

B. Jung and His Analytic Psychology: Dr. C. G. Jung, formerly a follower of Freud's, later gave up psychoanalysis and devised his own method of dealing with the psychoneuroses. Though he did not establish a school of thought, as did Freud, he was a valuable contributor to the subject. While he was with Freud, he identified and gave names to a number of Freudian concepts, such as the word *complex* and showed the importance of instincts other than the sexual. He worked out the concepts of extrovert and introvert in his book on *Psychological Types*—a classification which has largely taken the place of the old four-fold division of phlegmatic, choleric, sanguine, and melancholic. He prepared a word list which is largely used in word association tests, and he broadened the idea of the unconscious to include also benign and even useful complexes. In his most recent book he has developed a belief long growing in his thought: that religion is of great value both in the prevention and cure of psychoneuroses. His teaching regarding introversion and extroversion have been popularized by such writings as those of Dr. Henry

Charles Link,⁷ though this is but a classification of mental attitudes, not a means of diagnosis or treatment. The term *analytic psychology*, which he gave to his teaching, is but a variant of *psychoanalysis* and has little distinctive value.

C. Adler and His Individual Psychology: Dr. Alfred Adler, a pupil of Freud's, left his master and forsook psychoanalysis to give himself to his own form of treatment. He has secured considerable attention by his popular writings, and there is a great deal of truth and good sense in his books. While Jung taught that the chief urge in man was not sex, as Freud maintained, but the "will to live," Adler changed this into the "will to power." When the will to power is frustrated, there is developed in man an "inferiority complex" which is the cause of neurotic conditions. Adler used the term "inferiority complex," however, in a sense much wider than the popular. After a study of organ inferiority, he came to the conclusion that such organ defects or deficiencies have definite psychic results, and that physical defects, either actually discernible or perhaps beyond the reach of diagnosis, are the cause of an inferiority sense. He recognized the possibility of physical causes behind every neurosis. He also taught that there is a tendency in the mind to compensate for these conditions hindering personality development, and that often an over-compensation may lead into a neurosis. Anything from glandular dysfunctioning

⁷ Link, Henry Charles, *Return to Religion*, New York: Macmillan.

to red hair or bow legs may be the ultimate cause of a neurotic condition brought about through the development of an inferiority complex. Adler exercised a wide influence in the field of education, and he did valuable work in his lectures and in his work of advising children and their parents. The weak spot in his thought is in his over-stressing a very helpful concept, that of the inferiority complex, and in reducing all neuroses to an inferiority-complex problem. But there is much good in Adler's teachings, and most of his books may be read by neurotics without their gaining bad suggestions.

D. Dr. Edward Spencer Cowles and His Body and Mind Clinic: An original and suggestive approach to the problem of the psychoneuroses has been given in Dr. Edward S. Cowles' *Body and Mind Clinic* and in his recent book, *Don't Be Afraid*. Almost half a million patients have passed through the Clinic in the last twenty years, and the cures he has effected stand as a monument to the work of a great soul. It has been with him a labor of love, for his purpose has been to give relief to psychoneurotics even though people of modest means. The cost of treatments is ten dollars for the first month and five dollars a month thereafter. Four months is the length of time required for the slowest recoveries, ordinarily, while many are relieved of their neurotic condition in as many weeks.

Dr. Cowles finds the psychoneuroses to be the results of morbid or psychopathic fears induced in persons who are weakened through fatigue. Some

very difficult situation has arisen or some distressing experience has been undergone by the patient. It has taught the sufferer the feeling of fear and anxiety. He manages to weather the gale and begins again to live his usual life. But for some reason he is peculiarly susceptible to nervous fatigue, and his fatigue becomes a means of reducing his vitality and his resistance to the hard things of life. Then another terrible experience comes; his early fears return stronger than ever because of his weakened state, the result of his nervous fatigue. The neurotic, with his symptoms, is the result of this weakening of his nerves; he is cured by restoring the nervous system to its original strength and resiliency. For nervous weakness, Dr. Cowles believes, is actual cellular weakness of the neuron system, and in their weakened state the nerves are unable to check the impulses which flow unimpeded down the chains of neurons. The result is breakdown or collapse. Sleep, pleasant recreation, or diversion will repair the damage done to the nerve cells where the damage has not been too severe or of too long standing. Dr. Cowles also makes occasional use of a form of sedative and "nerve tonic" which assists the patient to a strengthening of the nerve cells and gives him a sense of rest and relief from strain and anxiety. In addition, a slight use is made of suggestion, given during relaxation. The method is unique and it does indeed produce very real results.

Dr. Cowles' teaching concerning fatigue, as the condition leading to neurotic conditions, does not

conform, however, to the studies of present day neurophysiology, though it does give to many neurotics new hope and a sense of security and direction. Historically, it seems to be an elaboration of the teachings of Weir Mitchell. Fear, if and when present, is a secondary condition; *anxiety* is the more exact word. To remove this anxiety and to show the patient that he is but the victim of his own amateurish and badly mistaken notion of his "feelings" is important in the cure of the psychoneuroses. The use of proper medication may be of great value, but the medication many patients receive is often of questionable value. For example, Dr. Billings says: "Luminal [phenobarbital], which is frequently given to relieve tension, is prone to slow up the patient's thinking and therefore may cause indirectly more anxiousness."⁸ He is writing of anxiety states. Yet phenobarbital, in the writer's experience, has been found to have been used very commonly in the medical treatment of all forms of nervous disorder. Dr. Cowles' medication is his own formula, but it is helpful to his patients. Suggestion is always of value, with some patients more than with others.

Two outstanding things may be said concerning Dr. Cowles' work: first, that it helps great numbers of people, and second, that it is a rare Christian, humanitarian work with a fine social vision.

E. Adolf Meyer and Psychobiology or Distribu-

⁸ Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*, p. 117, New York: Macmillan. Used by permission

tive Analysis: Dr. Adolf Meyer, former professor of psychiatry in Johns Hopkins University, (retired in the summer of 1941), and the originator of his school of thought, has written no books. His writing has been limited to articles in professional magazines and addresses at medical meetings. His teachings have been given fuller expression by a number of his pupils who, with refreshing loyalty to their master, have given him full credit for his great work. Four of these former pupils have stated his case clearly: Dr. Edward G. Billings, associate professor of psychiatry in the University of Colorado School of Medicine, in his very valuable *Handbook of Elementary Psychobiology and Psychiatry*; Dr. Leo Kanner, associate professor of psychiatry at Johns Hopkins, in his standard work, *Child Psychiatry*; Dr. Wendell Muncie, associate professor of psychiatry in Johns Hopkins University, in his text, *Psychobiology and Psychiatry*, and Dr. Esther Loring Richards of the same university, in her *Introduction to Psychobiology and Psychiatry*.

Dr. Meyer's foundation idea is that the individual functions as a whole, not departmentally, and that all the influences working upon him, within and without, must be taken into account in any accurate study of personality functioning. This is in harmony with all scientific and medical study. Freud and the psychoanalysts narrow the field of study of a nervous disorder to the patient's psychological reactions, in terms of a transcendental

and esoteric scheme of things, while Dr. Meyer requires a thorough study of the personality as a whole. Studying a "psychoneurotic," the method is one of a practical approach and consists essentially of indirect and direct examination procedures.

The *indirect* examination begins with a study of the patient's complaints and the problems he feels need attention. The complaint problem includes the problems as defined by responsible relatives, by the patient's own volunteered statements, and by careful questioning concerning his own attitude toward his difficulties. The complaint problem is then evaluated as to its genesis through the history of its development. This story must be elicited in all its important details, with the physical, mental, and nervous symptoms the patient feels, in terms of the setting in which the difficulty began. Then follow the personal history, birth, early life, usual and unusual experiences, illnesses and medical experiences, general health, the home setting, early nervous symptoms, activity of thinking and emotion, habits, school experiences, work record including work and recreational habits, financial condition, interests and ambitions, successes and failures, sex life, marriage relations, and family life. Also, the personality traits of the patient are studied. Is he shy or sociable, shut-in or interested in others, painstaking or careless, affectionate or cold, sympathetic or indifferent, satisfied with life or possessed of a martyr complex, cheerful or

depressed, kind by nature or hard, generous or stingy, a leader or a follower—every quality of personality which may be noticeably present or absent. Then must be secured the family history, showing the presence or absence of nervous conditions, alcoholism, psychopathic states in any members and especially the ideologies of the group and the “mores” playing upon the patient. What were the general and specific personality characteristics of his forbears and of his immediate family. What of the family emotional life? Any suicides? Com-mittals to any sort of state institution? Their cultural and educational standards?

The *direct* examination includes the physical examinations by proper diagnosticians, the psychiatric and neurological examinations, together with any special tests. The psychotherapist must include all these data in his diagnostic formulation and in his treatment plans and procedure.

There are occasions when free association is of value in ferreting out forgotten memories, and word association tests may be used. Dreams are not frequently used, though if the analysis of dreams offers therapeutic opportunities they are utilized for what they may be worth, along with attention to the patient's actions and reactions.

When all these studies and tests are made and the results are brought together, the final formulation of the total problem of the patient is then made. Drs. E. A. Strecker and F. G. Ebaugh devised a chart which was later modified by Dr. Billings to

aid in formulating the problem for "diagnosis, prognosis, and treatments." It takes the form of a simple formula, I plus S equals P . I represents the main facts in the individual make-up under the headings of heredity, constitution, developmental factors, and habits in terms of adjustment capacity. S represents the situational factors present, drives and attitudes, psychogenic, educational, vocational, recreational, economic, organic or toxic, infectious or traumatic conditions. P represents the performance. This is a very useful scheme for reducing a mass of material to an organized whole. It aids in preparing a working plan, a definite program of treatment. Whatever must be done to rectify wrong conditions of life or to orient the patient to a right life must then be undertaken, as well as every medical measure required. In a series of interviews the patient is given a complete understanding of his condition, how it came to be, and what is necessary for his recovery. There is nothing occult about the process, for it is a matter of leading the patient's thinking about himself into correct channels, righting him in every way, and placing him in the right situation, if it is possible, to secure normal and satisfactory functioning.

This method of distributive analysis is the most sensible and soundly scientific procedure available. There is more good common sense in it, it seems to this writer, than in any other method of approach to the problem of the psychoneurotic person.

Several problems arise for the pastor who desires

most earnestly to follow the Meyerian way of dealing with neurotics. In the case of the milder forms of neuroses, as "nervous" children, it is not necessary to go through a long and comprehensive psychological study. A few words from the patient, an interview or so, may reveal the whole condition, which may be cured in another interview. The patient may report one or more physicians to whom he has gone as assuring him that he is physically sound and that it is "only a case of nerves." This may be all the medical help the pastor can secure; other more thorough and more comprehensive diagnoses may be unnecessary or not available. Few patients can afford either the time or the money to attend a clinic in a great hospital or be taken as a patient for some weeks or months "just for a case of nerves." Probably three-fourths of the population are definitely beyond the reach of thorough medical care, insofar as the psychoneuroses are concerned, largely because of the lack of public education in such matters. A large percentage of the people are for the same reason, as well as because of low incomes, outside the care of the dentists, the oculists, and the surgeons.

So often the best psychiatrists are connected with great hospitals, especially state institutions for the "insane." To send a psychoneurotic to such an institution may add fuel to the flames, for the patient adds to his fears the conviction that he is definitely "crazy." In addition, the procedure of legal committal to these institutions is still an

ordeal in some states. Dr. William A. White says in his *Twentieth Century Psychiatry* that this procedure is "stupid, cruel, archaic and unnecessary."⁹

There is also the fact that, in the case of the psychiatrist in an institution or in private practise, the long period of time required and the amount of money involved often render his services impossible. The same is of course true of the medical studies that ought to be made of a patient. In the great majority of cases outside the great cities, the pastor must take what medical help he can get and be thankful, working with the neurotics from the psychological and religious angles while hoping there are no physical involvements. At least he can create a strong, resilient, and courageous mental attitude, and that is of value under all conditions. The writer has had several cases like this of a woman of forty-two years of age who was "cheered out" of his office by her family physician, and later by two other physicians, all of whom told her it was "only nervous." She manifested a depressive condition, with a history of two abortive suicide attempts. We worked hard with that woman for four months without results. Finally she was sent to a great hospital in another city where an operable condition was found, and with the operation all her neurotic symptoms disappeared.

These situations are not the fault of psychobiology, they occur as well with any form of medical

⁹ White, William A., *Twentieth Century Psychiatry*, p. 102, New York: W. W. Norton. Used by permission.

or psychiatric care, but a careful attempt to follow the principles of the Meyerian school of thought is limited, for the pastor, by the conditions suggested. Nevertheless it seems to this writer that Meyer's is by far the best method for a pastor to follow in working with neurotics.

2

Procedure for a Pastor

IN ALL SCHOOLS OF THOUGHT THERE IS A GENERAL plan of procedure which is followed in dealing with a psychoneurotic, and a general plan, in some form, must be followed by any pastor who is careful to keep his work in harmony with scientific method. Dr. Billings has outlined the technique he follows, and the writer shall endeavor to follow it in this book.

Dr. Billings places the eliciting of the complaint first, the indirect examination second, and the direct examination third. This is of course the logical order for a psychiatrist working in a great hospital, but for the pastor it is best that he begin with the medical study of the patient. The preliminary interview will make it clear what sort of patient is to be treated and what medical attention has been given and by whom. If there has been no satisfactory diagnosis and medical diagnosis is available, this should be obtained before the pastor begins his procedure. What medical care the patient requires should be under way before the pastor has his first interview. The patient should be requested to secure from the physician a letter showing in a general way the extent to which the nervous condition may be the result of bodily conditions and what is being done for any physical, neurological,

or psychiatric difficulties, and also a statement concerning the patient's condition as it may be dealt with by the pastor.

The matter of the pastor's difficulty in securing this sort of co-operation from the doctor has been spoken of and need not be repeated. But the fact must be stressed that in many of the pastor's cases the best he can do is to send the patient to the best available physician—a step which the patient's family doctor may not like—or else accept the patient's account of the physician's statement to him. The patient has probably visited a number of doctors, each one of whom has given him the best possible indication of a neurotic condition: a different diagnosis. The writer had one patient who had recently seen six physicians and had received six different diagnoses, four of them agreeing, however, that it was “chiefly nervous.”

I. Eliciting the Complaints

The eliciting of the complaints is the first step in the interviews beginning after the results of the direct examination are known to the pastor. Careful notes must be made as the interviews proceed. The writer uses a pocket-size notebook when visiting people outside the office, a separate notebook for each person. It is important to get down the patient's own words whenever they are relevant. At the close of each interview the notes for the day should be briefly summarized. The questioning

should be suggestive rather than too pointed and direct, in order to avoid any tendency of the patient to rebel against probing. Kindness and a generous consideration for the feelings of others are never bars to securing accurate information. Dr. Billings and others stress the importance of accuracy in making the record of the interviews. Inaccurate records are of little value.

The complaints should first be explained freely by the patient in his own words. What troubles him? What does he come to the pastor for? Let him tell his story to attentive ears and he will talk, for a neurotic is always ready to talk about his condition to one who will listen. When he has gained ease in talking to the pastor he must be helped by discreet questions. What other complaints are there? Is that all? Would he be well if these were cleared up? When does he feel best? How can he best relieve his bad feelings? How long do they last? What brings them on? What must he avoid to keep them away?

II. The History of the Complaints

This leads into the further discussion of the history of his present complaints. How long has he had these conditions? What condition was he in before they began? When was he last well? Under what conditions did they first come on? What was it that first suggested to him something was wrong? What were the conditions of his life at the time—

home, family, work, income, social life, responsibilities, problems, hardships, disappointments, strain, and fatigue?

From this the patient is lead to discuss his habits at the time his present complaint began. Drinking, medicine taking, sleep, guilt, sexual experiences, grievances?

The facts thus elicited, combined with the information received from the medical reports, provide the outlines of the picture of the whole condition of the patient.

III. The Personal History

The personal history should then be secured. The patient's age, where born, the type of home and family life, his relations with his father, mother, brothers, sisters, friends, and teachers, his school record and social life. When his mind is thus running back over his early years, put the question, "What is your very earliest recollection?" These early recollections are retained because they seemed important and interesting to him as a child, and they will often give a very revealing picture of the patient as he was in infancy. This picture is sometimes of great value in gaining an understanding of the personality trends today.

Then must come the study of the patient's years between infancy and the present, bringing out whatever in his experience may be of value. What part have finances played in his life, what successes

or failures? What are his likes and dislikes? What unusual experiences did he have? Any tragedies in his life? Drunken father or mother? Any deep impressions from past experiences? Sex experiences? Wrong doings which have aroused a lasting sense of guilt? Was he understood or appreciated? What fears did he have and what was their origin? Any early nervous conditions? Punishments or misfortunes? What did his associates call him? What did his parents consider his great faults? Any striking point should be noted concerning his habits, interests, work, play, hobbies, mistakes, bad conduct such as stealing, lying, or cruelty, or any noticeable characteristic or deficiency in his personality. Striking mannerisms, gait, speech, posture, or nervous habits may be significant. All this information may be gained in ten-year periods, or better yet according to the natural periods of infancy, youth, young adulthood, married life, and later mature life.

IV. The Personality Traits

The personality traits of the patient must then be recorded. By this time these will be apparent and little questioning required. Is he sensitive, shy, and shut-in, or sociable and friendly? Suspicious? Moody? Conscientious? Careless in every way? Aggressive? Submissive? Easily hurt and inclined to brood? Or tough-minded? Cowardly? Does he have a wounded-animal attitude, desiring

to slink away, be ugly, and lick his wounds? Surrender easily like a quitter? Are his ideals high or low? What is his religious history? Does religion really help him? What is his real attitude toward its value to him? Is he satisfied to get along without it? Is he ambitious or slothful? How does he evaluate success? With what is he satisfied? Does he have a sense of responsibility to his job or his home? Are there any hardships he *can* take and how does it happen that he can? What of his regular daily habits of getting up, cleaning up, meals, work, spending evenings, etc.?

V. The Family History

The fourth study must be made concerning his family history. What sort of health has characterized the members of his family and his parents and grandparents? Any feeble-mindedness? Any insanity? Epilepsy? Pauperism? Alcoholism? Tuberculosis? Their longevity? Any suicides? Were they a happy or troubled people? Nervousness? How did they get along with their neighbors? What of the family cultural level? Their education? Any special exceptions? What work did they do?

VI. The Formulation of the Problem

With all this information it should now be possible to formulate a clear summary of the condition of the patient and the history of the condition.

What are his outstanding personality traits and trends? Where did they begin and why? What attitude toward life does he manifest now? What is the final appraisal of all the information which has been assembled? The final formulation of this picture should be as simple a statement as possible, showing what his condition is and what the possible causes may be, and put into a few sentences which will be understandable to the patient. Such a formulation must always remain tentative, even though it seems clear and satisfying as it stands. Long after the study has been completed the patient may reveal something new which radically alters the picture.

This formulation should be gone over with the patient and discussed with him until he is in entire agreement with it. He is thus brought to see himself as he is. Great care must be exercised in avoiding too much insistence, for such a practice will break the rapport, the trustful confidence, which exists between the patient and the psychotherapist. The patient should be lead to see it and express it for himself rather than be "told" about himself.

VII. The Plan of Treatment

The plan of treatment must then be worked out along with the making of the final appraisal of the personality, and the first step is to explain the procedure to the patient. It has been brought out by a number of authorities that the treatment really

begins with the first sympathetic questioning of the patient. His being drawn out allows him to begin to see himself as measured by normal standards. The whole study of a person is at once diagnosis and treatment. The plan of treatment, however, which continues through as many interviews as may be necessary, deals with the re-orientation of the patient to a right life, as defined in Chapter IV and in building up right reactions to life with all its pleasures and problems. The symptoms will have been discussed fully under the heading of getting the complaint; and they will be returned to frequently by the patient for it is these troublesome feelings which the patient believes are making him "nervous." But he must be brought to see that the causes of these symptoms, which lie down deep in his reactions to life, are what must be faced, settled, and solved. The symptoms will disappear as soon as he begins to get his personality defects straightened out. He must be shown clearly how he should have reacted to his problems, and he must find the path to right reactions in the future. This matter of making over his reactions must be presented in successive interviews; and while no promise should ever be made as to the length of time required before the person is restored to health, the interviews should be terminated at the earliest possible moment, or as soon as the patient has made sufficient progress to be able to carry on his new way of life without help. The patient is being converted, in terms of psychiatry, as well as religion, and he

must learn as soon as possible to grow strong in his new life by his own efforts.

At this point, when he seriously begins to rectify his reactions to life, the patient should be brought to see that many of his fears and frightening feelings come to him because he himself has made an amateurish and much mistaken diagnosis of certain not at all uncommon experiences and has frightened himself about them. Like the person who is frightened by the thought of having cancer or tuberculosis, he is basing his fear upon his own morbid imagination rather than upon fact. He has analyzed these strange feelings, and has decided they are of a serious or dangerous nature—which they are not. They are but the fleeting, morbid thoughts which pass through every person's imagination. The well person is unimpressed by them and proceeds to dismiss them, but the nervous person is frightened by them and dwells upon them. The more he dwells upon them the worse they become. He is simply frightening himself by his own blundering diagnosis.

The pastor must not be disturbed by the patient's set-backs, for these will occur until the new reactions have replaced the old and he has again become acclimated to a normal life. Sometimes the cure of a psychoneurotic will require a surprisingly short time, two or three interviews being sufficient. In other cases the time may run into many months. DuBois says that when a patient believes he is on the way to recovery he is more than half cured. To

build up an anticipation of recovery, even of immanent recovery, but without venturing to say how long it will take, is good practise. There is nothing mysterious about the cure. It is a matter of patient, wise, kindly, and hopeful re-education. Every step the patient takes in the right direction must be pointed out and praised.

Throughout the interviews the pastor must be calm, full of assurance, kind, modest, and unshockable. He must be able to enter into the mind of the patient; and while he himself is sympathetic and understanding, he must awaken in the patient hope and confidence that his recovery is assured. He is not tinkering with a man's life; he is building a new personality to take the place of the old one. He has the basic assurance that, though a psycho-neurotic has had a bad start in life, it is possible for him to be changed, and a new personality reaction pattern substituted for the disordered one.

It must always be understood that the treatment is two-thirds listening and giving the patient an opportunity to re-evaluate the business of living. The therapist must be in a neutral position with the patient; he must never force himself or his peculiar experiences upon the patient.

VIII. Bringing Religion to the Patient

Because the pastor believes religion is necessary to the normal life, the right life, he is convinced that no disordered personality is brought to himself in

any complete way until he has been given a sound and sane grip on religion. He must have an adequate philosophy of life, a sensible idea of the reason for his existence, and a worthy purpose in life. There must be adequate ideals and the ability to approach them; there must be hope and faith and joy in living. All these and more come from religion, the greatest single integrating and perfecting force in life. Without this no man is capable of living his best life, and this is especially true of the victim of a psychoneurosis. The religion a person has may be not only futile as a means of help, but also it may be a power for unhappiness and neuroticism in life. There are bad religions, religions which develop weak, fearful, and badly disordered thinking and living. To believe in his religion is not enough, for as St. James says, "even the devils also believe, and tremble" (2:19). A healthy, rational, factual religion, a religious experience worked out in the clinic of everyday living, such as is outlined in a later chapter, is of transforming power in any life. Personality in disorder is an inevitable result of the absence of good religion.

There are many religious techniques which may produce the same sort of results. Some may prefer a more emotional appeal to a man's sense of sin and his need of repentance, in a sort of personal "revival." Those who make use of more Catholic practices may make use of the Sacrament of the Altar and the Sacrament of Penance. Father Alfred Newbery of Chicago made most excellent

use of these in his work. One might say that any method which gets results is justifiable, but we cannot open the door to charms, "divine healer" methods, or temporary "cures," even though their devotees profoundly believe in them.

3

The Personality as a Whole in Disorder

AT THE TURN OF THE CENTURY PSYCHOLOGISTS, William James, J. Royce, and others, were proclaiming the unity of man, and how he was made up of two interrelated parts, body and mind. It was left for later psychologists to gain a fuller understanding of the completeness of that unity. Today it is recognized that man is one organism, that body, mind, and emotions are but convenient terms of reference rather than the names of entities, and that in the study and treatment of disorders of an individual these and every fact bearing upon his life must be taken into account. It is important for the pastor to have some working understanding of the relationships existing among the various functions of personality in health, disease, or disorder. The purpose of this chapter is to indicate something of these relationships.

Any personality problem may result from a physical trouble or may produce a physical disorder. Mental or emotional conditions may proceed from physical ill health or be the cause of it. To attempt to treat a psychoneurotic condition, for instance, without taking care of the general health is like attempting to put out a basement fire without doing anything about the fire in the attic. The pastor should be able to discern something of the

signs that a nervous person may need bodily healing or psychiatric care before he attempts to meet the personality disorders with psychological or religious help. Above all things, the pastor must avoid the "divine healer" stupidity of taking all comers and promising health and happiness if they only have "faith." Such a dependence upon the credulity of nervous people and the attempt to bring them to believe in "prayer," in the "miraculous" or "healing power" of Christ, is what has made it almost impossible for the medical profession to believe that ministers have anything which does not belong to the realm of the occult. This has seriously hampered the co-operation which ought to exist between the doctor and the minister. The faith-healers and quacks of the world can cure only an occasional neurotic, and the wise pastor will recognize this fact and base his work upon the solid ground of medical science and rational religion.

I. Physical Conditions as Causes of Neuroses

Some nervous conditions are the result of environmental or bodily causes, while others come from the personal life. The materialistic view of nervous disorders would always postulate a physical condition of some sort as the cause, but the fact remains that changing the thinking and emotional life will cure many such cases. But there are many tendencies, weaknesses, bodily defects, or abnormalities which may contribute to a nervous

disorder. Any disease or dysfunctioning of the body, from a common cold to a cancer, has its definite psychical effects. Less important bodily defects such as sensitivity to heat or cold, a low fatigue point, an excitable heart, passing pains from strains or muscular fatigue, a lack of sleep, or slight digestive disturbances, will also contribute to the development of a nervous state. Conditions such as being too tall or too short, too fat or too thin, having crossed eyes or glaring red hair, eccentricities of gait or manner, peculiarities of speech or oddities of conduct—all may give rise to self-consciousness and morbid thinking, which in turn usher in a neurotic state.

All such conditions, however, are but the means of attaining a neurotic personality rather than the cause of it. The reason why one person reacts badly to such things while another is all but unconscious of their existence must be sought on deeper levels of personality than that of the body. The difference is that one possesses a “neuropathic” make up while the other does not; one has an inherent weakness where the other has strength. A constitutionally nervous person may be more seriously affected by disease or by trivial discomforts than another who “has no nerves”; one can laugh off or ignore things that would make an invalid out of another. The nervous condition is the result of the particular sort of reaction the individual makes to his troubles. This is a matter of personal equation.

In every case it must be emphasized that the phys-

ical causes of a nervous condition must be studied and treated before the pastor attempts to treat the nervousness. Without proper medical care or environmental change, in so far as such change is possible, the pastor might as well "rub milk on the shoe heels" as to attempt psychological or religious treatments.

On the other hand, it is possible to cure nervous disorders, or very greatly to relieve them, even though the physical trouble continues unrelieved. If the patient is taught the strong, stoical attitude, or the serene sense of security which religion can bring, he will be able to rise above pain and disease and live a good life in spite of them. This ability to live down physical infirmity is one of the glories of strong, resilient human beings. It is the pastor's task to create such triumphant spirits, even in the face of the terrors of suffering and death.

II. Physical Results of the Psychoneuroses

There is no line which can be drawn between those diseases which are of "nervous" origin and those which result from purely physiological causes. But enough is known to make it abundantly clear that neurotic states can and do produce morbid physical conditions. These in turn may lead to structural disease.

Any strong emotion, such as fear, anxiety, hate, or anger, will have its physical effects. Fear is a common example. When fear seizes a person there

is an initial sense of weakness and confusion, both physical and mental. This is quickly followed, in the normal person, by a counter reaction, a new access of strength and courage. Some medical authorities as Louis Berman in his book, *Glands Regulating Personality*, and Dr. Walter B. Cannon in his, *Bodily Changes in Pain, Hunger, Fear and Rage*, show how the adrenals, by discharging adrenalin under the effect of strong emotion, produce various phenomena which bring strength and vigor to mind and body to fortify it against emergency. If, however, adrenalin is discharged too frequently there is produced a state of adrenalin insufficiency. In this condition there is produced a fatigability, sensitivity to cold, cold extremities, a loss of appetite, a tendency to worry, indecision, and "nervousness." Thus, physical changes result from an emotional experience. A nervous person is, by his fears, frightening himself all day long, and it is not surprising that he cannot sleep when night comes, that physical dysfunctioning appears and he develops the symptoms of a nervous disorder.

Another approach to the matter of the psychoneuroses causing physical disorders is given by Dr. Walter C. Alvarez in an article in the "Journal of the American Medical Association" for September, 1940. He shows how the autonomic nervous system, when in an unstable state, will play disconcerting tricks on the heart, the blood vessels, digestive tract, kidneys, or skin. He mentions a number of conditions which may result, such as

dizziness, faintness, palpitation, rapid or irregular heart, intestinal crampings, diarrhea, frequent urination, bloating, and closing up of the nasal passages. These conditions result from fear or rage; they may come from a tired brain, from overwork, or from sorrow. Dr. Alvarez makes the interesting suggestion that the primitive brain in lower animals, represented in man by the hypothalamus, controls the functioning of the heart, lungs, kidneys, and other internal organs, and it in turn can be controlled by the higher brain, which enables man to think, reason, and remember. When control over the lower brain is inadequate, the primitive brain fails to function properly and there follow the functional disturbances of the visceral organs. If this is true, it would indicate the great importance of the higher brain's assuming control over the emotion-and-passion-driven lower brain. All this seems to be in harmony with the fact of common experience, that it is failure to face reality with the mind which gives rise to the emotional conditions and disordered thinking spoken of as nervous disorders.

The relation between a dysfunctioning organ and an organic disease is a problem for medical students rather than for the pastor, but it should be noted that the line between functional and organic has practically disappeared from modern medical thought. The organs which are disordered by bad emotional states may have already become involved in a structural disease. It seems clear that long

continued morbid states of dysfunctioning do indeed result in physical disease. It has recently been reported by Dr. H. Flanders Dunbar, that half the deaths and disabilities in the population are due basically to emotional strain. She found that out of 1,500 patients having high blood pressure, several kinds of heart maladies, diabetes, gastric diseases, and other diseases, 80 per cent had psychic conditions as important components. Long standing emotional strains alter the key organs of the body and prepare them for disability and disease. Dr. White in his *Principles of Mental Hygiene* writes, "The number and duration of physical and apparently physical disorders which may originate at the psychological level is endless. It includes many forms of asthma, sore throat, difficult nasal breathing, stammering, headache, neurasthenia, backache, tender spine, 'weak heart,' fainting attacks, exophthalmic goitre (Grave's or Basedow's disease), aphonia, spasmodic sneezing, hiccough, rapid respiration, hay fever, gastro-intestinal disturbances, (constipation, diarrhea, indigestion, colitis, ulcer of stomach) ptosis of kidney, diabetes, disturbances of urination, polyuria, incontinence, menstrual disorders, (auto-intoxication from long standing digestional disturbances), nutritional disorders of the skin, teeth, and hair, etc."¹

A physician recently recorded the story of a

¹ White, William A., *Principles of Mental Hygiene*, New York: Macmillan. Used by permission.

native Filipino who brought on his own death within twenty-four hours, though there was no medical evidence of disease. The Filipino was convinced that a tribal medicine man was right when he assured the native he would die in that time.

The moral of all this is that nervous disorders are not to be allowed to continue so long as they may be cured, for they are not negligible disorders.

III. Mental Disease and the Psychoneuroses

The pastor must be on guard, if he is working without adequate medical guidance, against confusing psychoneurotic conditions with the psychotic, on one hand, and, on the other hand, expecting more than is possible from the mentally deficient. A psychoneurotic condition may be but the beginning of a major psychosis, and a person in this state should be put in the hands of a psychiatrist at once. In fact psychoneurotic reactions may sometimes be more serious than more psychotic ones. On the other hand, the pastor may attempt to secure normal reactions from a mind that is structurally below normal. To avoid both these blunders, it is imperative for the pastor to be able to recognize the symptoms of both mental disease and mental deficiency. Not infrequently he may be the first to be called to meet such a problem, and he should know something of the diagnosis of the two states. This is particularly necessary in small towns and cities without psychiatric specialists.

A. Dementia: This is a general word for those alterations of personality commonly called insanity. They occur among those who have already acted and worked normally or near normally but who have developed strange and sometimes alarming changes in behavior. There are no sharp lines which can be drawn between normal minds and those with slight aberrations in mentality, for the borderline is very broad. In the same way there is no sharp line of demarcation in their beginnings between neurotic conditions and psychotic. Perhaps two-thirds of all the major reaction forms began with "nervous" symptoms, though the psychiatrist finds major mental changes recognizable from the beginning.

In discriminating between the major and minor reactions, certain symptoms become the deciding factors. In either the major or minor reactions the total personality is involved, but in the minor the manifestations are evident in some of the person's functions only while in the major the personality is involved in a sweeping way. The victim of a psychoneurosis can usually, at least in the earlier years, carry on a normal life, though with a great deal of anxiety and complaining. The victim of a major reaction cannot successfully face life wisely or safely, and his whole personality, physically, mentally, emotionally, and in every way, is disturbed by his condition; he is out of adjustment with society and a serious problem to his family. Without intruding in the field of the psychiatrist, whose

task is to diagnose, classify, and treat the victims of mental disease, we may outline the most characteristic symptoms of the major reactions.

1. **DEPRESSIONS:** A mildly depressed state may accompany any nervous disorder, but a depression which is serious and lasting is a condition for the psychiatrist. Having the blues, being moody, or being temporarily depressed—these are fairly common experiences for certain types of personality. In a serious depression the joy has gone out of life entirely and the patient cannot smile nor respond normally to any happy emotion. A deep gloom settles down upon him like a fog. He lives under a cloud of hopelessness. There is an ominous feeling of gloom which attaches to all his thinking. Certain things distress him more than others, such as sleeplessness, strange feelings in the head, as of fullness or solidness; digestion does not function normally, his sex appetite vanishes with his desire for food, he loses weight, is slow in thinking and in general behavior. Some of these symptoms may appear in a neurotic, but a major depression is noticeably more serious. The patient is fatigued and often feels he must lie down most of the time. Other emotions, such as anger, rage, hate, and fear, may be active, and these may be projected toward his friends. There may be a feeling of shame, a belief that his condition is the result of his own wrong doing and that he is suffering punishment for it. There is the hopeless belief that he is not going to recover, and he is convinced that any efforts made

in his behalf are futile. He is filled with constant apprehension and anxiety, and he is completely surrendered to it. So long as he can recognize the abnormality of his depression and can have some success in rising above it, there is the possibility that it is neurotic rather than psychotic.

Such depressions are always serious. The great danger is always that of suicide, and perhaps half of such patients do succeed in taking their lives. Many times it is difficult to determine the depth of the depression. Even the psychiatrist may not be able to recognize the seriousness of this condition, and there are instances of a person with an apparently mild form of depression taking his own life as he steps out of the doctor's office. The pastor should waste no time getting a depressed patient into an institution or the hands of a competent psychiatrist.

2. **MANIAS:** In this condition the patient is apparently free of the normal inhibitions to abnormal behavior and is completely possessed by a pressure of ideas. In comparison with a normal state of happiness, this state is one of grotesque exaggeration, for his excited words and acts are manifestly not sane. He has baseless feelings of happiness, ideas of grandeur, and acts foolishly and with wild enthusiasm. The patient may write a check for ten million dollars, think of himself as President, King, or God. The strangeness of such behavior, when a manic state has fully developed, is only too easily recognized by the family. There are forms of

mania which may lead to danger either to the patient himself or to his family. Such a state appears only in minor form in a neurosis and then chiefly as a simulation of mania in hysteria. Mania in any form is definitely a problem for the psychiatrist. The pastor's concern, after a physician has been called, is for the family.

3. **ALTERNATIONS OF MOOD:** In manic-depressive conditions, depression and mania follow one another in some sort of pattern. The depression may be followed by a period of calm or by mania, and this cycle will be followed in later manifestations. When such a condition appears as a new thing in a person, it is clearly psychotic.

4. **SUSPICIONS:** There may develop a feeling of unusual suspicion in the patient, a condition definitely at variance with his usual self. All that is said or done will seem to be done against him with malign intent; he feels that others are watching him, laughing at him, or attempting to harm him. The neurotic person is always sensitive to what others say and do in relation to him, but it does not pass over into definite suspicion so long as the condition remains psychoneurotic.

5. **DELUSIONS:** A delusion is a false notion, an idea which is palpably untrue and unreal but which seems dreadfully real to the patient. He is convinced that though it seems unreal to others he is absolutely right in the matter. Many normal people have queer ideas—for instance, that cubism is art or that Hitler is a great soul Americans should

come to love—but still these may not be of the nature of delusions. Inventors and all original people often seem deluded to their friends, but time has vindicated some of them. A delusion does not stand the test of time, it is not in harmony with the facts, it runs contrary to reason, while the person who holds it is adamant to reason and argument. The depressed person has the delusion that he has committed an unpardonable sin or that the devil is after him, while in the exaltation of mania there come the delusions that the possessor is some great person or that he has invented some world-startling device.

6. HALLUCINATIONS AND ILLUSIONS: As delusions are untrue and grotesque ideas and beliefs, so illusions and hallucinations are unreal sights, sounds, or other sensory experiences. They create impressions which are as real and terrifying to their possessors as though they actually existed. The devil may appear, or frogs, snakes, and insects, as in delirium tremens. God may appear, reproaching the patient for his sins; he will hear strange voices and mysterious sounds and smell distressing odors. These experiences may become so real that the patient may become violent and dangerous in his efforts to protect himself against them. Hallucinations seldom appear as psychoneurotic phenomena, and if they do they are more in the nature of phobias than realities.

7. FUGUES: The sudden loss of memory while a rational attitude toward the present environment

is retained, as in the case of amnesia is termed a fugue. Yesterday's life and environment may drop from memory entirely but the world of the present may be vivid and real and may remain so for months or years. The condition may result from long continued strain or emotion, excessive tension, anxiety, or fear. Slight fugues, which are but exaggerated states of absent-mindedness, occur rather commonly in normal people as well as in neurotics, but a protracted and very definite lapse of memory is a psychiatric problem.

8. STUPORS: In this state the patient goes mentally blank, in varying degrees; it may be a partial stupor or it may become complete as in the case of catalepsy. Stupors are of course not pastoral problems.

All these symptoms of major reactions do not often occur in pure form but are more often combined with symptoms of other states. The human mind in disorder refuses to follow any rules. The pastor's task in all these conditions is to maintain a gentle, kindly, sympathetic yet neutral attitude, allowing the patient to hold his own particular ideas without argument or harshness. The physician or psychiatrist should be called at once. The pastor should stay close to the family through all the bitter formalities of legal commitment. Moreover, he is justified in holding out some mild hope for the patient's recovery. Not being a physician, he may, without danger to his reputation or pro-

fessional standing, give hope which a physician would hesitate to promise. Modern methods of study and treatment of mental disease are returning a surprising number of psychopathic patients to their homes and to a participation in the normal life in society. It is also helpful for the pastor to remove, so far as he can, the great fear and the sense of disgrace which most families have when one of their own becomes mentally sick. Such an affliction should be looked upon as any other disease. Disease of any sort is a great shock to the family, just as is an operation, but there is no possible blame to be attached to the patient or to his family. It might have been a gall-bladder condition or a mastoid, but it did not happen to be. The old days of cruel penal treatment of those who lost their reason are now past. In modern institutions the care of the mental patient is on a par with that given any other hospital patient. Moreover, it must be remembered that the prognosis in psychopathic cases is surprisingly good.

The increase in mental cases is a serious indictment of our modern manner of life. Dr. W. A. White, in his *Twentieth Century Psychiatry*, gives figures to show that practically half of all hospital beds in the country are filled with mental patients, and in each generation one person in twenty-two suffers from some sort of mental illness. Many interesting facts are given also by Dr. Neil A. Dayton in his study of 89,190 Massachusetts cases, *New Facts on Mental Disorders*. He finds that

males outnumber the females six to five. Unemployment had very little effect in increasing commitments. Mental disease appears increasingly with the approach of old age, a condition which shows a definite relationship between psychotic disorders and the physical weakening and breakdown of the body. Foreign-borns show the highest rate of increase. Chronic alcoholism appears as a serious cause of mental disease, one-fifth of all admissions showing alcoholism as a contributing factor while one-tenth of all cases are diagnosed as alcoholic psychoses. In the first year of prohibition, when the restrictions were taken seriously, there was a striking drop in admissions. The happily married have the smallest chance of having mental trouble, then come the widowed, the single, and the divorced with the highest incidence. Three hundred per cent more divorced persons are admitted than married people. There are more cases of senile forms of dementia than of all other psychoses together.

The outlook, however, is hopeful. The medical profession is meeting the challenge of mental disease with great earnestness; research and clinical study and treatment are yielding good results. It can confidently be expected that the future will present a much brighter picture.

B. Intellectual Handicaps: This condition, often called feeble-mindedness, includes the great body of those who manifest reactions of intellectual retardation. The child of this type lives his life with a defective mind as a result of conditions arising

before birth, during birth, or in the early years of life. Dr. R. L. Dixon, formerly superintendent of the Michigan Home and Training School at Lapeer, lists the causes of mental deficiency under the following heads: pre-natal influences (perhaps five per cent), infection, injury, deteriorating processes, disturbances of metabolism or nutrition, new growths, unknown causes, and undifferentiated cases.

These intellectually-handicapped persons live with a certain fixed mental capacity—fixed for life. Training may improve the ability to perform certain tasks, they may be more able to use the capacities they have, and they may be better adjusted to society; but the amount of mentality remains unchanged. Mental tests of the same individual over ten- or twenty-year periods show little if any change in mental endowments.

The degree of mentality is measured with a fair degree of accuracy by means of striking an average of several tests. Some form of Binet-Simon test for general intelligence is used, and various performance tests, such as the Knox Cubes, Healey pictures, Mazes and Kohs Color Cubes, are employed. The average of six or eight such tests gives the mental age, abbreviated as the *M.A.* Most feeble-minded persons are unequal in their development, one test may show a mental age of fourteen while another will reveal an eight-year old mind. Sixteen years is considered the normal mental age. For purposes of convenient reference, the mental

age is reduced to months and divided by the number of months of the child's actual or chronological age. Persons beyond sixteen years are tested by using the mental age of a sixteen-year-old child. Sixteen years being 192 months, the figure 192 is used in all computations for older persons. Chronological age is abbreviated *C.A.* The formula, then, is $M.A. \div C.A. = I.Q.$, the Intelligence Quotient.

The feeble-minded are subject to neurotic disorders in decreasing rates, according to mental age. To be neurotic requires a certain amount of ability to reason from cause to effect, vivid imagination, and a desire to think of one's condition. The lower types of intellectual deficiency are not neurotic.

The usual classification follows:

1. **NORMAL:** *M.A.* 15-16, *I.Q.* 90-100. These are subject to psychoneuroses.

2. **DULL, OR DULL NORMAL:** *M.A.* 13-14, *I.Q.* 80-90. Probably a larger percentage of the population come within this classification than we like to think. They will always be thirteen- or fourteen-year-old children in mentality. Among them, however, are some excellent citizens. A passing acquaintance will not reveal their low mentality; they take their place in business, politics, and social life. They may even be geniuses along certain lines. They are unstable, emotional, easily worried, easily made anxious about themselves and often morbidly body-conscious. They are potential, if not actual, neurotics, going through life seeking panaceas, living on patent medicines, becoming faddists, and drifting

into alcoholism or sex irregularities. They are followers of the crowd, good-natured, and conventional, rather than progressive. All these traits break out in moments of frustration, hardship, or disappointment. They are unable to bear the blows life deals out to them. Their neurotic conditions can be cured, but patience, assurance, and simplicity of language and thought must be used. Otherwise the study and treatment of them proceeds as is explained in later chapters.

3. BORDERLINE: M.A. 12-13, I.Q. 70-80. In these people the conditions found in the dull group are more pronounced. They, too, are often found making a fair success of life, making good in their work, and sometimes possessing social gifts of a sort. It is not necessary to segregate them, except for certain of the low level who cause trouble, for in most cases they can carry on satisfactorily in ordinary life. These borderline people, however, often find it impossible to cope with life and its problems and responsibilities. They drift into the dependent or near-dependent poor class. Many of them are public charges, for life is just a little too much for them. They easily develop nervous trends and symptoms, though their usual happiness and hopefulness mercifully keep them from too much worry over being unable to keep up. They are to be treated as one would treat other twelve- or thirteen-year-old children. Kindness and appreciation of their good points and praise wherever it can be given go a long way to opening the door to their confidence.

The simple matter of being interested in their birthday, always a subject of perennial interest to these children, will open the door to their hearts.

4. MORON: M.A. 8-12, I.Q. 50-69. These "children" will not be troubled with psychoneuroses to any serious extent. They take their bodies for granted and only the most obvious defects trouble them. Their fears and worries are those of children. Some live freely and fairly successfully in society, working, marrying, and, unfortunately, bringing children into the world. They may keep house well, become good servants or clerks, or may do various sorts of factory work. They may be good citizens. On the other hand, the lists of city poor and pauperized farm hands, and their families, are filled with these people. They are often sexually perverted or unmoral. One moron, for example, had nine children, each by a different "husband."

5. IMBECILE: M.A. 4-8, I.Q. 25-49. There are no neurotic problems among these. Idiot: M. A. Inf.-4 yrs., I.Q. 1-24.

The minister has the task of persuading the parents of such intellectually handicapped children to have them institutionalized. Also, he has a duty to help educate the public to the urgent need of sterilization for them. Preventing conception can in no possible way be construed as destroying life. The operation is a simple one which does not alter normal sex functioning but prevents procreation. A feeble-minded person left to run about in society is a constant problem and danger. It is

a moronic idea that maintains they should be allowed to bring children into the world because their offspring might possibly turn out to be geniuses. A study of the records of the Jukes family ought to convince any unbeliever of the need for sterilization. Miss M. Whitney, psychologist at the Michigan Home and Training School at Lapeer, made, in 1934-5, a study of the descendants of a moronic couple born about 1855. Of the 128 descendants of this couple, 31 had died and their maximum age at death was 55; 24 were feeble-minded; 22 were in state institutions, tuberculosis hospitals, hospitals for the insane, and prisons; 14 were still-born; and 14 were of illegitimate birth. This leaves 23 without evidence of weakness, except that a number of them had been for years on the lists of county poor.

These conditions should be sufficient to make it clear to pastors that they should do their utmost to educate parents, educators, and children to the fact that "all men are *not* created equal," for they vary physically, intellectually, and emotionally, as in every other way. All children cannot attain the same goals, but they must be accepted in school and out as possessing what they do have and no more. There must be a place provided for them in society, but they and society must be safeguarded against their limitations and weaknesses. Those children born handicapped should be given every opportunity to serve society except that of bringing children into the world.

IV. Psychoneuroses Leading to Mental Incompetency

DuBois makes the statement that a neurotic is closer to being well than to having a major brain disorder. Still, a long continued psychoneurosis can lead to incompetency. Whatever may be done to prevent that, by clearing up neurotic conditions, is clearly a step in the right direction. To be useless to himself and to society and a burden to his family—that is a situation which ought to be prevented; and the pastor has his chance to help.

4

The Right Life

I. Nature and the Right Life

BY THE PHRASE "THE RIGHT LIFE" WE MEAN LIFE lived in pursuit of its highest goal, its perfection. It never attains its ideal or the ideal ceases to be an ideal, for an ideal must always remain beyond attainment. The life which is right is the properly oriented life, the life headed toward its highest and best. It is seeking always that goal and, though constantly failing to reach it, has the satisfaction of feeling that it is on the way. After every failure, it picks itself up and makes a new beginning.

Everything living in God's world has something of an urge to perfection pulling and pushing it on toward a goal. It is found in a quartz crystal—these always obey the laws of their nature which tend to make them perfect quartz crystals. Always and everywhere it will have a chemical formula of Si O_2 , it will have a standard hardness, will crystallize in hexagonal form, have the same lustre, and will be unusually transparent to ultra red and ultra violet rays. It may have defects but it will always tend to be a perfect quartz crystal. A cell will obey the laws of its life with the same regularity, and it can be said to live its right life when it approaches its ideal state of existence. So a farmer does his

part to raise a crop but he depends upon the inner power of his grain and hay and stock to perfect themselves.

Not only is this right life right in itself but it is right also in relation to others. It must be able to integrate itself with all other manifestations of right life, both in its own kind and other life. In man's case, his right life is not only right within himself but right in relation to other human beings.

There is a commonly recognized standard of right life acceptable to all men everywhere when they are at their best. A warped, twisted, or degraded life has lost sight of the ideal, and all the personality suffers as a consequence. This universally accepted standard of right life is one lived with the hope of securing health of mind and body, freedom from frailties and handicaps, and the physical and mental ability to live a normal life. It is the life of truthfulness, intelligence, honesty, self-control, kindness, courage, common sense, happiness, and peace. Against these, as St. Paul says, there is no law, though individuals and even nations may be led to hold these in contempt. In relation to others, it is the life of respect for others, of patience, forgiveness, helpfulness, and good will, and, that highest of all social virtues, self-sacrifice. Mothers the world over teach their children that these things make the right life; all religions embody them in some form. Men differ limitlessly in their definitions of these characteristics, but the basic principles are always there. The right life has

its inner enemies in ill health, accident, fear, pain, loss, and bereavement, while it has outer enemies in the weak living of other people, the blunders, stupidities, and sins of men, together with the bad standards of the social order in which we live, all of which make it harder to live the right life. But always the right life is there if we will follow it, a shining road to health and happiness perhaps but always to victorious life.

II. God and the Right Life

In the life of the crystal, the cell, the growing grain, or the animal on the farm, this urge to perfection is followed automatically. If the conditions are favorable, there is no possible way a tomato seed can fail to become a tomato plant or the ovum-spermatazoa combination refuse to produce a human life. But with man there comes a new power, that of choice, for he can obey or refuse the inner call to the right life through his own decisions or his family's bad conditioning. There is nothing inevitable about evolution, for a man can go down as well as up. But it is this call in man to the right life, this inner good sense, which man has always called God. Behind the scenes there is a great planner, maker, or administrator of all, and in his best moments man seeks to make contact with his God, and to obey Him. Great souls through all history have expressed this call of God to great behavior as the essential aim and purpose of life. Micah expressed

it 2,600 years ago (6:8): "He hath shewed thee, O man, what is good; and what doeth the Lord require of thee but to do justly, and to love mercy, and to walk humbly with thy God." Jesus himself stated it: "Thou shalt love the Lord thy God with all thy strength." This is the first commandment. And the second is namely this, "thou shalt love thy neighbour as thyself." It was because Jesus knew he was living this sort of life that he was able to say, "I have come that they may have life, and may have it in abundance." St. Augustine, out of his varied experience with life, said, "Lead us to Thee, O God, for our hearts are restless unless they find rest in Thee." W. T. Grenfell of Labrador expressed it in his characteristic way, "The thing that makes life wonderful, the thing that makes life worth while, is to know that you live in a world that needs you, and that with God's help you can meet that need."¹ Thus God is leading men to their high adventure, that of living the right life, of behaving as Jesus taught the world, by word and example, the right life ought to be lived.

III. Jesus and the Right Life

To those who seriously try to follow Jesus He is the perfect teacher and example of the right life. To approach Him as one standing in the great multitude that followed Him, listen to His voice, watch Him as He moves about, and study Him in

¹ Grenfell, W. T., writing in "The Churchman," New York.

His daily walk with men, is to catch a glimpse of the perfect life, the life God desires of us all. The amazing and easy companionship He had with God, and His patient, forgiving, and kind way with even the most unpleasant human beings, the heavenly graciousness of His life, all make us want to say to Him with Thomas, "My Master and my God!" That good and right life we know we ought to live was possible for Him and He lived it, while we stumble and fail and fall. And without discussing Christology or attempting to define in the terms of philosophy the relationship of Jesus to God, we recognize in Him our Master, our teacher, and our message and messenger from God.

IV. Jesus Technique for the Right Life

Jesus did not leave us in doubt as to how He lived as He did, for He left us one great teaching, reported in St. Matthew 6:9-13 and in St. Luke 2:2-4, and given in response to a request of the disciples that He teach them how to pray. In His reply He gave a perfect summary of His own religious experience, and in the fifty-five words of the Lord's Prayer we find the great essentials of the good news He brought to mankind. It expresses what He longed for, what He prayed for, and how He gained the faith in God which so gloriously expressed itself in Him. We see in it the great motive which actuated His life. But He gave it all to His friends and followers in order that it should be

their religion as well, and that they might be able to know how to follow Him as He had urged them. The years do not dim that crowning human achievement, and Jesus is as much our Master and our God as He was for His disciples, even though they lived with Him in the flesh.

There are three great "facts and acts" expressed in the Lord's Prayer. The first has to do with the life *with* God, the life of fellowship and companionship with Him; the second expresses the life *for* God, the intentions and the acts which are man's part in religion; and the third, dealing with the life *from* God, expresses the confidence of man in God and what God does for man in return for his life for God. In greater detail these three points are:

A. *The Life with God*: "Our Father, who art in heaven!"

These two phrases express the relationship one should have with the Father. A brief commentary on these words will make the meaning clearer.

"Our": Though this prayer is to be used by the individual or the group, the outlook expressed is as broad as all humanity. As one says *our* Father he stands in the great multitude whom no man can number and raises his voice in behalf of them, as well as of himself, as he addresses the Father of all. There is nothing narrow or selfish in it; all selfishness is eliminated in the great humanity-wide vision we share in using this word.

"Our Father": These are the words of address to God, as one addresses a friend whom he ap-

proaches by name. There is something intimate in the use of a name. It opens the door, and we stand in His presence when we speak to God by name. When these two words are thoughtfully said, they usher us into God's presence, and there are times when He seems to warm us with His greeting. Whether this occurs or not, the prayer so begun has reality, while if these words are mere formalities the whole prayer trails off in unreality. The name Father does not bar the use of other names for God, for there are times when we cry out to God the Protector, the Guide, the Friend, the Comforter, the Strong One, or the Lover of our Souls. Father was the word most often used by Jesus. For those who have had worthy human fathers, there is reality and power in the name.

"Who art in heaven": These words locate God as the first words approach a definition of Him. Where God is, there is Heaven; for Heaven is that state in which all is as it ought to be, loving, true, strong, happy, and triumphant. Heaven is the ideal, the perfect; and wherever there is something of this, there God is. It was a great rest and refreshment to Jesus' spirit to lift his eyes and mind to Heaven for a moment when life was hard and dangerous, and He came back from that taste of Heaven refreshed and serene. Something of this experience should belong to every follower of Jesus. Heaven is no problem for him, for he has seen it; he has been there.

These mountain-top experiences of Jesus were

momentary and fleeting, as they are in every human life. To attempt to live in that rare atmosphere makes for pure mysticism and fruitless other-worldliness. One must return to earth after these high experiences, but return "trailing clouds of glory."

B. The Life for God: "Hallowed be thy Name, Thy kingdom come, Thy will be done, On earth as it is in heaven." This is the life *for* God.

"Hallowed" means to set apart as holy, to consecrate above common things.

"Thy name": This is a Hebraism for God Himself, the name standing for all that God is. To avoid profanity is implied in the words, but this will be an unnecessary council to those who really love the Father. No man who appreciates and loves God will use God's name in vile and wicked language and in uncontrolled moments. The phrase means then, "May God be first, above all other loves, all other interests!" But it is a longing which is expressed here—not only an expression of how I feel about God but a longing that all mankind may come to put God first. "May everybody see Thee, O God; and may I do my utmost to help bring men to center their lives in Thee! There is nothing else worthy of being hallowed but Thee!"

"Thy kingdom come!" The desire to have God become central in the lives of men leads to the desire that they dedicate their lives to His obedience. Not in worship only, nor in the desire for God to be hallowed, but in that men may give them-

selves to the coming of the Kingdom of God. God's Kingdom was the central thought in the teaching, the parables, and the conversations of Jesus. The idea of the kingdom is simple. Any kingdom is made up of king and people. The people are loyal to the king, they obey his laws and serve him, they give themselves in loyalty to him. The king requires the loyalty of his subjects, and their obedience; and for his part he provides for them, he protects them and, if he is a good king, loves his people. So in God's Kingdom there is the loyal service of the citizens of the Kingdom, and there is the care and protection of the subjects by the great King. This is the principle of the covenants of the Old Testament; they are agreements between God and His people, each pledging their lives to the other and each depending upon the other. To say "Thy kingdom come!" then, is not only to wish for it but to dedicate one's life to doing all one can to help bring it to reality; and the follower of Jesus is dedicated above all things to the endeavor to bring the Kingdom of God to this earth just as it is in Heaven. It means to live and work for love between man and man, for forgiveness, patience, generosity, helpfulness, and self sacrifice. It means a genuine Christian life in the individual and a Christian social order in society. It is both the personal and the social ideal of Christian men.

"Thy will be done!" This carries out the thought of the coming of the Kingdom, for to work for the Kingdom is to do the will of God. God's will is not

some dark fate which brings catastrophe and sorrow to man, but rather it is the plan of God to bring fullness of life. To do the will of God is to do every right and good thing, it is to live to please God. God's will is for man to live the ideal life, or at least to aim after it; it is to do every righteous thing Jesus would do were He in our bodies. It is essentially a matter of behavior. Behavior, then, becomes the central thing, the main purpose of life. Not belief, not emotional experience, but right living is the one thing needful in a truly religious life. The right life grows out of the companionship with God, but it must grow out of it or it is failing to express the will of God.

C. The Life from God: The rest of the Lord's Prayer deals with the blessings we are confident God will give us in sufficient measure if we but do our part. It expresses a strong resilient faith grounded in obedience. It is not credulity but *faith*. It is based upon the belief that if we do our part we can leave it to God to do His. He is trustworthy.

"Give us this day our daily bread": Bread here means everything for "every day's most common need," food, shelter, clothing, love, sufficient health of mind and body, opportunity, work, and other things necessary for a normal life. This is not a half-hearted wish, it is a request with complete assurance that it will come to pass, but if it does not then, in the goodness of God, something else good is coming from Him. And in the long run

that other thing will be seen to be worthy of a good and loving Father.

“Forgive us our sins as we forgive those who wrong us.” This is a better translation than the conventional words of the prayer. The phrase expresses what naturally follows the dedication of self to doing the will of God, that we forgive those who wrong us. We ask for forgiveness because we believe God in His justice will grant it, for it is His nature to forgive. Forgiveness is one of the surest gifts of God.

“Lead us . . . but not into temptation”: It is unthinkable that God would under any circumstances lead His children into temptation, and these words cannot possibly mean that for God is a loving Father. It is a prayer for leadership, that God may be trusted to guide us through all the difficulties of life. Then, as an afterthought come the words: but keep us from falling into temptations which are too hard for us, from the temptation which may break us. It is a proper thing to ask God, and it is right to feel that God will lead us around and away from such perilous temptations, so long as we are set to serve Him and are seriously doing it.

“But deliver us from evil”: In any event, keep us from going to the devil, from wasting our opportunity to live, for this is what Hell means. Here again we trust God to deliver us from this dark possibility and the prayer is one of confidence.

Jesus technique for living the right life may

then be summarized as, first, speaking to God and uniting our lives with the great Integrator of all life; then, giving our attention to doing with eagerness and joy the things that please God; and, finally, leaving the outcome to Him, trusting past, present, and future to His care. These may further be summarized thus: placing ourselves in harmony with life and with God, doing the things which are right and thereby gaining a clean, wholesome conscience, and having the faith which removes the mountains of fear, anxiety, and all the other dark emotions which take away the joy from life. The resulting behavior is the right life, loving, strong, and confident; it is the sort of life which prevents and cures the miseries of disordered personalities.

V. Psychotherapeutic Values in Jesus Technique

The value of these three principles of the right life to the intellectual and emotional life are:

A. Orientation: A speaking acquaintance with God means *orientation* toward God, toward life. Most people are conditioned to believe that there should be a relationship between men and God, that prayer should be a regular thing, and that the ideal of this relationship is a sense of companionship with Him. The Lord's Prayer approach to God is the simplest, least controversial, and most practical method of attaining this *rapproch* with God. The need of this *rapproch* is basic in man's experience, and to gain it is to put a solid founda-

tion under his thinking and feeling. Man feels that he is in harmony with the universe, that he is in touch with the Source of all strength and happiness, that he is "right with God," and that he is appreciated and loved. This orientation is fundamental to mental health.

B. The Meaning and Purpose of Life: The great human question, "What is the meaning of life?" is answered in the Lord's Prayer by the teaching of putting God first, seeking and living for His Kingdom, which means doing His will. That is what life is all about, and he who has discovered what it means to live in obedience to God, that His rule on earth may become more and more a reality, has found the answer to the great question. It gives a reason for life which is intelligible and practical, and at the same time it becomes a glorious ideal.

C. Confidence: To be oriented toward God and to live and work for His Kingdom of love "on earth as it is in Heaven" is to gain peace, a serene sense of security, and all the hope and happiness which come with these. This is the perfect love which casts out fear. One so actuated, and rewarded by such confidence, assurance, or faith, has the secret of living above the fears and anxieties which torture nervous people. His is a resilient, courageous, and victorious life.

To possess this religious life is to have that of which DuBois spoke: "Religious faith would be the best preventative against the maladies of the

soul and the most powerful means of curing them, if it had sufficient life to create true Christian stoicism in its followers. In this state of mind, which is, alas! so rare in the thinking world, man becomes invulnerable. Feeling himself upheld by his God, he fears neither sickness nor death. He may succumb under the attacks of physical disease, but morally he remains unshaken in the midst of his sufferings, and is inaccessible to the cowardly emotions of nervous people.’²

VI. The Right Life and Religious Education

It is the task of religious education to teach and inspire the living of the right life, and to keep that perfect ideal of human life before those who would call themselves Christians. It should concern itself with the physical, mental, and emotional, as well as the moral and religious, welfare of the family of God. Its task is thus vastly greater than that of teaching certain Bible and Church information, conditioning children for conventional relations with the Church. Whatever affects the functioning of the child, as a child of God and as a follower of Jesus, belongs in this field. It is clear that “religious education” is not a broad enough term for the task to be accomplished, if right conditions within and without the individual are to be produced, so far as they can be produced, and if the

² DuBois, Paul, *Psychic Treatment of Mental Disorders*, p. 210, New York: Funk and Wagnalls. Used by permission.

best possible approach to the right life is to be made. Perhaps part of the pitiful uselessness of most of our "religious education" is due to this very limited field in which it works. When the whole Church sets itself to work in the wider field of eliminating the hindrances, so far as possible, to living the Christian life, the right life, and in clearly presenting that strong, courageous, loving, and believing life, which the right life is, then the Church will merit and receive that confidence which it expects. Systematic work in producing personal adjustments to life will become the new work of the Church. Such a work should begin with infants and carry on through adult life. It is a very large order, but it is the proper task of the Church, if it is to give the world the richness and fullness of right living.

5

The Wrong Life

THE WRONG LIFE, THE OPPOSITE OF THE RIGHT LIFE, is of course that life which does not function properly, successfully, or economically. It is not to be expected that the right life will ever function perfectly, for there are limitations of body or mind or conditioning which prevent a fully right life. Where there are defects in one part of the personality, as in the body or in the education, which are overcome or compensated for in other areas of life, as in mind or spirit, the life is rightly lived. But where the defects are untouched and are allowed to break or seriously impair the functioning of the rest of the personality, the life is wrong. The poorly functioning person is surely living the wrong life, whether his uncompensated weakness is physical, mental, emotional, moral, or religious.

A brief statement of the conditions leading to personality failure may be made without repeating what has been said as to the conditions necessary to the right life. They may be summed up as follows:

I. Physical Disease and Dysfunctioning

Too often organized religion has overlooked the part bodily ailments play in producing sin. Sin in all its forms has been considered volitional: "He

could do right if he only would." But any bodily defect or sickness may be the cause of slow thinking, fatigue states, worries, fears, anxieties, inattention, inability to concentrate, dullness, gloominess, warped thinking, and a host of other varieties of disordered functioning which lead away from the right life. Even slight physical disturbances may be sufficient to cause very troublesome breakdowns in morale. A headache may turn a cheerful soul into a pessimist; a state of auto-intoxication may bring gloomy hours and fears of insanity; even indigestion may produce thoughts of cancer and death. A rugged, extrovert type of person will not be affected by these conditions, but a sensitive nature may be. Any personality failure may have had its beginnings in some simple bodily ill.

II. Mental or Emotional Disturbances

A long period of hard concentration on one's work may bring on a worried, fearful, and anxious state. The attempt to think out problems which are too deep for the individual may produce a state of exasperation, of being baffled and beaten, which is definitely morbid. One may be hurried and driven too fast for his natural pace and mental fatigue of confusion will appear. Thwarting or habitual contradiction, especially during states of physical indisposition, may arouse anger or cause depression. In the same way a long continued emotional strain because of unhappy family situations, daily

work under trying circumstances, and problems concerning children or other members of the family are typical causes of dark and morbid feelings and emotions. The emotional strain of a deep sense of guilt or the idea of physical or mental breakdown are sufficient to produce wrong trends in life. When these intellectual or emotional problems or burdens become suddenly extreme, they may be all that is required to precipitate a neurotic condition long smoldering in the mind and heart. So also volitional weaknesses, the exasperation over possessing so weak a will, will cause wrong symptoms and wrong living. This, in turn, may be the result of a bodily weakness or defect, or it may proceed from an idea which has slipped into the mind and never been fairly faced and dealt with. Such conditions affect us all; they arise out of the most commonplace experiences of life and appear in infinite forms. The wrong life results only when wrong reactions are made to these endless testing times in everyday living. These problems may assume menacing proportions in times of war.

III. Environmental Factors

The many weak and wrong influences brought to bear upon modern life, in the home, in social life, in business, and in political and national life, make it exceedingly difficult for a child to be brought up without being influenced by wrong trends. The prevalence in everyday life of fears and misgiv-

ings, of doubts and uncertainties, of the broadcasting through the papers of every horrible crime, the lies told blandly in radio advertising, the selfishness of high-pressure salesmanship, the greed in business, the ruthlessness and cruelties of much social behavior, the lust for pleasure and excitement, the willingness of people to slip into illiteracy after the completion of their formal schooling in high school or college—all such influences, especially in a generation tried in the fires of a world war, are bound to produce tremendous problems of wrong living. It is not only that these weaken and break the adults who have to live with them, but also these social weaknesses are taken with the mother's milk. The coming generation has to pay.

IV. Religious Pusillanimity

Against these tremendous handicaps to right living which face every nation on the earth, organized religion is, in large part, a broken reed. It is still talking the language of a century ago, and it has made no use of the vast knowledge available to it in the minute studies in human functioning which have been made by psychiatry. Sin is still limited in popular thought to a certain list of violations of moral traditions, while it does not include the vast influences for evil in the social, business, and industrial, as well as physical, mental, and emotional life of the people. Every sort of abnormal condition, criminal, psychoneurotic, or psychopathic,

is dealt with by the ministers with injunctions to "read your Bible," "pray over it," "accept the Lord Jesus," "come to the Communion," or "come to Mass." The Church feels it is not its affair to have anything to do with these thousand and one causes of wrong living, not its affair to work toward their elimination. Because the Church has often felt the futility of its amateurish ways of handling these problems of human life, it has abandoned these fields entirely, limiting its work more and more to the specifically "spiritual" phases. It is not hard to see whence comes the widespread feeling that the Church is giving little toward the solutions of the problems of wrong human living.

Specifically, the Christian Church has failed to make real and vital to most of its people the three religious essentials of a right life. It has not tied its members to a life-giving companionship with God, with all that means to those who have it. It has not given a central purpose to the lives of its members, that of living in and working for the Kingdom of God. It has not produced a great faith in God, the healing faith which removes mountains from the hearts and minds of men. When the Church attempts to touch the problems of nervous and other conditions, it still does it in the terms of "spiritual healing," while shutting its eyes to the determining factors involved. DuBois, an avowed agnostic, wrote in *The Psychic Treatment of Nervous Disorders*, in 1904, some words which might still apply to the religious "healers" in the

Churches today. After he had looked into the healings going on at Lourdes, he found that the physicians in the "bureau of statistics" there were men "mentally of such a nature that their observations lose all value in my eyes." To which he makes the cryptic comment, "but Lourdes is not very far from Tarascon." The central weakness of the Church is that it is not producing that sort of belief in God which Dick Shepherd called "betting one's life on God." Without that, man is unable to meet and overcome the trouble which flows from the frustrations and denials of life, the humiliations, the losses, and the guilt, all of which open the door to wrong living in any and all of its forms.

V. Three General Types of Resulting Bad Reactions

Human reactions are so complex and confused as to render any neat classification impossible. But the writer will venture upon a very loose classification of wrong reactions, for the purpose of eliminating many sorts of bad reaction with which this book is not concerned.

A. Mediocrity: The vast majority of men and women never rise to the great possibilities in them; they illustrate the truth of the statement of William James that people are only ten per cent efficient; they do not use more than ten per cent of the possibilities and powers given them. With a very tenuous hold on God, with petty and shifting aims

in life, and with no great faith to sustain them, they live feebly, opportunistically, and drably. In this great body of mankind are found the scatter-brained and unreliable, the weak personalities, the touchy, the bull-headed, the spiteful, and those with uncontrolled tongues and tempers set at hair-trigger; there are the gloomy, the disheartened, the humorless, the pessimistic, the critical, the cynical, the surly, the irresponsible, the over-conscientious, the impulsive, the sluggish, the complacent, the irritable, the boastful, the timid, the greedy, the intrusive, the shy, the indifferent and cold and the effusive and shallow, the solemnly over-serious, the pompously egotistical, and the "good but good for nothing" people. All such unhappy and unpleasant personalities have missed the good life. Life has been a little too hard for them, and they are always potential cases of other forms of weak and wrong reactions to life.

B. Crime: These emotionally over-developed or emotionally immature persons, who have formed the habit of making wrong reactions to life, may end up in criminal institutions; though many of them never resort to overt crime, managing to stay within the letter of the law or shrewdly planning to evade the law. Crooked politicians, dishonest and heartless business men, lazy and careless workers in any field—all come within the potential criminal class. All these who "want what they want when they want it" and who, untroubled by any other considerations, are determined to get it, are po-

tential criminals. Pure specimens of this type are as difficult to find as pure specimens of any other wrong form of life. Only a careful analysis makes it possible to determine where the responsibility lies. But here it is necessary to do no more than mention this class of personality breakdown and pass on to the next type of bad reaction.

C. Nervous Disorders, the Psychoneuroses: In a very general way the mechanism by which psychoneurotic conditions develop, whatever the cause, whether physical, mental, emotional, or found in the history of the individual, is as follows:

(1) The feeling that something is wrong, that one is oppressed by being mistreated, hurt, or neglected; by having to give up comforts, pleasures, or being pampered; by believing these wrong conditions are not only unavoidable but inescapable and unbearable. These conditions and ideas are dwelt upon more especially in times of trouble, fatigue, or confusion. At such times they call insistently for attention.

(2) Anxiety then fills the frightened soul, and there is the tendency to surrender to the threats of evil. This stage gives rise to such phrases as, "I can't stand it any longer!" "These feelings have me whipped," or "I must be having a nervous breakdown." Too often this mood is developed by over-sympathetic friends or family, and even the family doctor by his concern may encourage the patient's alarm.

(3) This condition may appear in the form of

attacks, or it may be a sort of habit reaction with which the person lives. Longer or shorter periods of time may intervene, and during the most of the patient's life there may be little trouble from these uncomfortable experiences. He may be adjusted to live within certain well-defined limitations, and fill a fairly normal place in society. At this point he substitutes some sort of symptoms, not by deliberate choice; and these are his scapegoats. They play the part of the causes of his troubles though they of course are not.

(4) But some day there comes a fresh assault of neurotic symptoms, brought on by some experience or chain of hard circumstances. Then the nervous person surrenders to his condition, he feels himself unable to resist and gives up to fright. He loses the connection of his condition with his entire make-up and history, and sees in his present symptoms the cause of his whole situation. This is the usual picture of nervous disorders.

VI. The Classification of Nervous Disorders

No final classification and naming of nervous disorders has ever been made. The conditions have been called *nervous* from the early days of modern medicine. Toward the close of the last century they became the subject of study because of the great interest in the matter of hypnotism as a therapeutic measure. At that time all nervous conditions were lumped together under the name

of *hysteria*. Many obscure diseases of those days, such as chorea and tetanus, were studied as possibly "nervous." DuBois says that such diseases as paralysis agitans, Basedow's disease, or exophthalmic goitre revealed intense emotion as a determining cause but that they cannot be considered as nervous disorders. The line between psychoneuroses and major psychoses was and is hard to draw. After leaving out conditions which though nervous were of bodily origin, and also the psychoses, DuBois applies the term psychoneuroses to those conditions which result from wrong ideational and emotional life, as well as numerous other causes, but which do not send their victims to psychopathic institutions and which permit a certain amount of normal life in the homes and society. This delimitation of the nervous disorders under the name of psychoneuroses, in contradistinction to the psychoses, has in the main continued down to the present time.

But the classification of the psychoneuroses still varies with different authorities. DuBois lists them as "neurasthenia, hysteria, hysterical-neurasthenia, psychasthenia, the lighter forms of hypochondria, and melancholia, as well as certain conditions of mind more serious, bordering on insanity and hard to classify."¹ Dr. Myerson speaks of three general classes: neurasthenia with also hypochon-

¹ DuBois, Paul, *Psychic Treatment of Mental Disorders*, New York: Funk and Wagnalls. Used by permission.

drias, psychasthenia including phobias and compulsions, and hysterias in their various forms.

In this book we desire to follow the lead of Dr. Adolf Meyer and his pupils. Dr. Meyer has coined a new word to express, in place of such words as *conduct* or *behavior*, the total functioning of a person—largely because these words do not readily lend themselves to the formation of plurals, adjectival uses, or compounds. He has devised the word *ergasia* from the Greek word *ergazomai*, to work, to do, to act. Psychiatry finds some conditions which affect the entire personality in a sweeping way, and these Dr. Meyer calls *holergasias*, meaning the major psychotic states. The disorders which, however, only partially affect the personality, the psychoneuroses, he calls the *merergasias*, from *meros*, part.

Dr. Billings in his *Handbook of Elementary Psychobiology and Psychiatry* lists them as general nervousness, tension and irritable weakness states, anxiety states and disorders of anticipation, the hysterical reactions and motor neuroses, hypochondrias, the obsessive-compulsive-ruminative tension states. The latter classification, however, is a borderline type of disorder which should be under the care of trained psychiatrists. Here we shall abide by this classification, except for Chapter VI, on nervousness in children.

6

The Beginnings of Nervousness in Childhood

I. The Importance of the Earliest Years

ADLER BELIEVED THAT BY THE TIME A CHILD IS FIVE years of age his "style of life" is a fixed thing. That is to say his tastes, his likes and dislikes, his abilities, trends, and interests, and the character of his emotional and volitional life are established. Whatever has become set as the style of life in these few formative years should remain as the bent of life throughout the whole of its duration, unless in some way the life would be made over in later years. Here then in infancy can be found the beginnings of selfishness or generosity, courage or timidity, strength or weakness, tough-mindedness or tender-mindedness, confidence, or fearfulness, decisiveness or uncertainty. Freud and others have held this same belief.

Drs. E. G. Billings and Leo Kanner add to this, however, the fact that the nervous child is a "special type of personality not common to any one culture, social, or intellectual level,"¹ and Dr. Billings adds, "the clinical phenomena are but the eventualities of variations in the functioning of relatively normal structures . . . which for various reasons are susceptible to the strains of ordinary

¹ Kanner, Leo, *Child Psychiatry*, Springfield: C. C. Thomas. Used by permission.

life.”² Why this is so, why one child will react normally to the hard things of life while another will be unable to stand up under the blows of “outrageous fortune,” is answered in the whole story of the particular personality involved, in his physical and mental being, and in his environment and history. One child is sensitive to fatigue while another is not; one is easily frightened and the other enjoys being scared. The nervous child is from his earliest days endowed with certain weaknesses; his more fortunate brother is without them.

II. The Complaints

Children manifest every form of nervous disorder found in adults, though they are usually in minor forms. The symptoms are countless. Among them are the following: fatigue and susceptibility to fatigue, lassitude, laziness, uneasiness, restlessness, touchiness, sadness, general unhappiness, weepiness, anger, temper, jealousy. There may be the uneasy feeling that something vaguely is wrong; they are easily discouraged and chronically below par; they may desire to avoid people and experience definite uneasiness in the presence of them, especially strangers; they may experience fear of high places, of the dark, of strange and mysterious forces, real or imagined. Sleep may be disturbed by bad dreams, nightmares, or terrors;

² Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*, p. 105, New York: Macmillan. Used by permission.

there may be sleepiness during the day and wakefulness or jumpiness at night, sleep walking, and bed-wetting or enuresis; feeding difficulties such as loss of appetite, fear of certain foods, slowness in eating, and playing with the food, refusal of certain normal foods, and strange notions about foods and eating. More serious eating difficulties are regurgitation and rumination; motor nervous habits such as fingering the face or clothing, a jerky gait, meaningless movements and twitchings, tics. There are speech defects, such as stammering and stuttering; indigestion, constipation, or diarrhea, cold hands and feet, "air-hunger," sighing, air-swallowing, and the tendency to fear certain diseases; sex troubles such as the thought of being "over-sexed," worry over sex-adventures, masturbation, and over-active sex imaginations. Every form of fear may appear in infancy and childhood, even to the fear of failure, of insanity, of dead persons, and of death. There may be fear of living, thoughts of suicide, and even suicide itself in childhood.

III. The History of the Complaints

It is not so difficult to determine the history of the complaint problems in a child as in an adult because the child is so much closer to the event. He can often recall the exact situation out of which his nervous trouble started. His parents may be able to give an accurate account of the difficulty.

The indirect examination may reveal the inherent weaknesses in the personality of the child. His nervous condition, as his whole personal development, is less complex than it becomes in later years, and it is more accessible.

The history of the complaint will reveal both the predisposition to wrong and weak reactions and the immediate cause of his present difficulties. The emotional and intellectual climate in which he has been brought up will be better understood when the personal and family history have been studied, but the immediate events which have precipitated the trouble must be related to the general picture of the individual's life. In the same way, the findings of the physician must be incorporated into the picture of the individual's ergasia.

There are several sources of information concerning the history of the present illness. The parents will usually be able to give the necessary information. It is often the case that parents may not be able to interpret the conditions as they should, but they can be relied upon to give firsthand information of what the child went through, what he said, how he acted, and when it took place. It is sometimes best to see the parents separately while at other times it is wisest to see them together. It may be that the mother or father alone will give all the information needed. In some cases neighbors, as well as other relatives, may be of value. School teachers may be of great value if they have known the child for any length of time.

Then the child must be seen. He should be encouraged to tell his problems and their history in his own way. The complaint must be elicited from him in the simplest, kindest, and most direct way possible. A solemn discussion with the child concerning his condition, running into many long interviews, is a serious error. It cannot help but deepen in the child's mind the idea of the seriousness of his condition. A brief, pointed, and cheerful interview with the child is good diagnosis and good treatment. One or two ten-minute interviews should be sufficient to secure the child's complaint history and his ideas concerning his condition.

IV. The Personal History

The personal history is taken with the idea of understanding the important experiences through which the child has gone and which may have exerted a determining influence upon his life. What is there in his past experience which has tended to make him react as he does? The story of his birth and babyhood will be gained from the parents. These facts are most important in understanding the child. Whether or not he is petulant, imperious, and stormy in nature, or calm, submissive, and happy will find its history in these early days in many cases. What was his nature as a baby and did he change? When did the change occur and what brought it about? What diseases did he have and what were his feeding habits? Sleep habits?

Other evidences of personality make-up? Did he have any frightening experiences as a baby? Falls, injuries, or punishments?

When the parents have presented the picture of the baby days, the child himself can be studied. A valuable first step, in case the child cannot throw the necessary light on the history of his condition, is to ask the child to recall and describe his very earliest memories. These are of great value in restoring the picture of the child as he was at three or four years of age. They may show that the beginning of his trouble came after that time, if his life then was happy and normal, or before the time of his earliest memories if those memories reveal a wrong state of mind. The mood of those earliest events, which have remained in memory because of their interest or importance to the child, is often very revealing. Then one proceeds to look into the events in the life of the child which may have been important in forming the present personality. What about frights or fears? Any hardships or denials, real or fancied? Any unhappy experiences with any persons? How about the attitude of others toward him? His attitude toward them? What of the feelings concerning older or younger brothers and sisters? How did they treat the child? What nicknames did the child have? What did the mother or father say were his great faults? What were his best points? Do others recognize them? All these questions deal with the pre-school period. The complaints should be traced back into these years or

beyond, if it seems to have come then, and the child's own ideas concerning them are of great importance. The personal history must make clear what made the child what he is and what he thinks about it all, so far as all this may be gained from the experiences he has had, and from his own reflections upon them.

V. The Family History

This subject includes everything in the family history and in the relations between the family and the child which may have any importance. If the physical examination by the doctor, the determination of the complaint problem and its history, and the study of the child's own history, have not already brought out the cause of the condition, this study should do it, for in a large number of cases it will be found in the home life of the child. It should be clear that all these steps need not be gone into in detail in every case, but in an obscure and difficult situation these steps must be taken with care and in detail. In many cases the physician's report and a few questions asked of the parents and of the child may be sufficient to reveal the whole condition. But it is important to keep the whole procedure in mind, for it may be necessary.

Many conditions in family life will already be made clear by the time this subject has been reached, for the events in the child's history will

bring them out. They should be checked up, however, under this heading.

The personality of the mother. "Like mother, like child" is a real truth. Especially in the infant, and decreasingly as the child progresses into adolescence, will the mother's influence be felt. What she is will be felt by the child long before it can think about it or talk of it. A mother can and does impart to her babe in arms very much more than she realizes of her feelings, her moods, her attitudes. Her fearfulness, nervousness, brooding, and unreasoning anger, or her calm confidence, self-mastery, resiliency, and quiet reasonableness, are conveyed to her child in its first few months. The child feels these things and will react to them and form habit-reactions long before the things show themselves. The infant's instinct to preserve himself against danger, pain, or hunger will catch these characteristics of the mother. The father's influence also will be felt if there are striking qualities in him. If he is under the influence of alcohol, angry and loud in his expressions, or threatens to injure the mother, the child will catch the feeling and will react accordingly. On the other hand, a loving, kind, and reasonable father will have a vast influence upon his child.

As the child grows, he becomes more sensible to the atmosphere of his home and his moods and trends reflect it. Many of the nervous conditions in children may be easily traced to such conditions. Illustrations of this are readily recalled. One little

girl of seven had an inordinate fear of being hurt and was so timid she would not play as other children. A neighbor revealed the fact that the loud-voiced and nervous mother used, as a favorite threat when the little girl was not more than three years old, "You stop that or I'll put you in the washing machine!" A young man of nineteen was suffering from fear of losing his mind, a fear he confessed had troubled him for years. His mother confessed to the writer that there was a time she had become exasperated, when the boy was five or six years of age, and had said to him, "What is the matter with your mind? There must be something wrong with your head!" And she wondered if that had had anything to do with his condition! In another case a wise mother was habitually overruled by a neurotic father who insisted that his little four-year-old daughter was "terribly nervous" and kept the thought before the child's mind. At eighteen the girl was a seriously psychoneurotic case. In all such cases the parents attitudes and acts may or may not have been the cause of the child's nervous condition, but at least they contributed to it. By the same token, broken homes and fighting or drunken parents are responsible for a great number of nervous conditions in children and over and over again the study of the family history will bring them to light. For a mother to say, in the child's hearing, "Johnny is no good in arithmetic," or that "Mary is such a very nervous child," is to add fuel to the flames.

To tell a child that he is lazy, a cry-baby, or a nuisance, does something which hurts a child very deeply, for the small child believes what his mother says is true.

Any experience which frightens a child and which is not properly explained away may be the seeds of a fearsomeness which will curse the child all his days. Practical jokes are inevitable among children, but morbid ideas should not be allowed to result from them. Discussing the news of the latest horrible crime or reading aloud the sordid details of it in the presence of the child (it is bad enough for an adult to read them) are inexcusable blunders fraught with great evils. Subjecting a child to a harrowing experience is of the same nature. A small girl was lifted up to see her aunt in her casket. The mother probably thought she was simply doing the loving thing or that she was teaching the child not to be afraid of dead people. But not content with that, she had the child take hold of the aunt's hand. For some weeks the child had a psychic paralysis of the arm, and for some months after that she could not eat with the hand. She is now a graduate nurse, still paralyzed with fear when a patient dies.

A great deal of harm can come into a child's life because of the domineering of an older brother or sister. The natural feeling of having to take an inferior position to an older sibling may grow into morbid self-pity or brooding. In the same way, when the new baby comes and all the attention is

taken from the older child and showered on the younger, the older child's nose is put out of joint. Adler has laid a great deal of stress upon these relationships between children.

Adler also brings out the harm which may come to a child by being pampered and sheltered. He is thus shielded from the natural hardships of every human life; and when the time comes for him to face the world and its bumps, he is without the resistance and the resiliency to meet them. A coddled child and a mistreated child are alike in their inability to "greet life with a cheer." A failure in school, inability to meet competition with other children, crossed eyes, red hair, bow legs, and similar personal peculiarities—all tend to "break the spirit" of the child with a nervous tendency. Poverty and denials, uncleanliness in the home, unhappy experiences with "superior" children—all deepen the neurotic tendencies of children. Parents who attempt to make all the child's decisions for him and who never allow him to grow up but continue to dominate him are laying up curses for their child in later years.

What it means to children to live in a world at war would take a chapter to discuss. The fear of the enemy, the fear of defeat, the stories of atrocities, and the horrors of battle—all have no place in a child's mind. The hate of the enemy, the suspicion of neighbors, and the losses of loved ones are serious in the life of youth.

The absence of any good religion in the home

or the presence of bad religion, religion which produces fears, self-consciousness, morbid introspection, and the sense of sin and unforgiveness, make a tragic atmosphere in which to bring up a child. When such a home gets religion, good religion, and the love of a loving God and happy service rendered to Him, together with a joyous faith in Him, become the rule of life, the home is transformed and the children with it.

VI. The Formulation of the Problem

The formulation of the problem confronting the child may be made when sufficient facts are in hand to make the picture clear to the pastor. All the facts must be gone over and the summing up made. Given the "nervous temperament," the constitutional weaknesses, the pastor may then see how the various experiences of the child have pressed upon him and have developed in him the psychoneurotic condition of which the symptoms are the substituted expression. For the symptoms are not the cause but the effect of his condition. The child blames the symptoms, as do the parents, but these are but the child's unconscious attempts to solve his problems. He has mishandled his problems because he has not understood them, and his wrong reactions are his best way out. The formulation must be so simple that it can be stated in few easy words; it must be clear and definite. New developments, however, may come to light, new

facts which have not come out at the right time; and the formulation may have to be revised to include them. There are times when the case is well along in the treatment and a new fact is unearthed which may cast an entirely new light upon the picture. As a result, the formulation must always be elastic; there must always be loop holes where new facts may be introduced.

VII. The Plan of Treatment

Just how the story of the child's condition is to be presented to him in the simplest, most direct way is the problem of preparing the plan by which the pastor will work. The story must be presented to him, so far as possible, in his own language, using his own words, in order that he may see just what has been wrong in his life and what the right way is. The wrong way should be touched upon lightly but surely, for no child should be brought to "a sense of sin." It must rather be shown him constructively; he must see how happy he will be when he reacts in the right way, and how his nervous symptoms will pass away when he is on the right road. The road to the right life must be shown as the way to happiness, strength, and success. The plan for presenting this will include a quiet understanding that he may always have to live within certain limitations, his constitutional tendencies. This presentation requires consummate tact to avoid planting new fears in the child's

heart. It must all be planned to interest him, challenge him, and give him a sense of victory. Never must the appeal be on the grounds of duty or grinding struggle.

VIII. The Reorientation of the Child

The two factors in curing the nervous condition of a child are the changing of his *milieu* and the rectifying of his reactions to life. This comes of course after the physician has made his study of the child and has instituted any therapeutic measures which may be called for.

The changing of his environment is sometimes as difficult as it is important, for it means changing the parents and the whole home life. If the parents are neurotic, it is particularly hard to do. But the facts must be given the parents and the effect of wrong conditions on the child clearly brought out. Drinking to excess, fighting, loud wrangling, brooding, fear and anxiety in the home atmosphere, unkindness or on the other hand babying, hatreds, and all forms of wrong conduct must be pointed out, and the connection between such behavior and the child's nervousness also must be pointed out. Such a change may be sufficient to overcome the child's trouble.

The other factor, that of changing the child's reactions to the hard things, the disappointments, the denials, and the thwartings of life, must be dealt with with complete candor and the weak

reaction trends clearly pointed out. Again the situation calls for great kindness, patience, and tact. The child must be brought to see himself as he is but without being discouraged or disgusted with himself, or without awakening resentment against the pastor. It must come to him as a lesson in personal efficiency, as a good teacher corrects her pupil's mistakes while keeping up his gratitude for being taught. No child resents being taught how to be a good swimmer or runner.

Adler had a way of asking a child perhaps less than a dozen questions. After encouraging and reassuring him while securing the facts, he stated in a few words the new reactions the child should have to life. For younger children, this is an admirable method. Older children will need more explanation and fuller discussion, but every unnecessary word used in talking to a child is not only wasted but has the negative effect of making the child's condition seem to him more serious than it is. The "least said the soonest mended" is a good rule in dealing with children.

It is, frankly, a very difficult thing to give children a hold on God if there is no worth-while religion in the home. There are striking exceptions, of course. But the three rules noted earlier, when put in the simplest terms, are the best way to impart a genuine religious experience, and they give the child who grasps them a genetic and dynamic hold on right living. Then, when the coming

years bring their share of disappointments, the child will be fortified against relapsing into nervous conditions.

IX. Treatment of Special Symptoms

Though the underlying personality weaknesses are the important things to be dealt with, rather than merely treating symptoms, it is a mistake to allow any symptoms to go on without being frankly faced and dealt with. The way out of the trouble must be clearly shown. The symptoms must be explained as substituted reactions. The child has had some common sensations and experiences but to him they have assumed terrifying or very troublesome proportions. He has seen danger where no danger exists. It is the mystery of common but new experiences, new to the child, which has made them objects of fear. There are a number of quite common symptoms which may trouble children.

A. Nervousness: Children have vague ideas of what nervousness is. If he has been taught that he has a "nervous temperament," it must be explained that he has the gift of a fine imagination, and imagination is one of the faculties which makes the artists, the inventors, the leaders of the race. But imagination must be brought under control; it must be used as a tool rather than permitted to use him as its tool. Everybody is "nervous" at times, there is nothing unusual about it, but it is

just a sign that one needs rest, play, or change. Learning to avoid tension by developing the ability to live in a relaxed state, physically and mentally, helps to avoid nervousness. The nervous person should be a little more easy-going, he should let his mind and body go on frequent little momentary vacations. Nervousness is often the result of living too strenuously, it is an indication of too much strain and stress in life. Perhaps one has too low a boiling point. If so he must live within his proper range and avoid boiling over or firing up. A nervous child needs relaxation, more play, more fun, more happiness.

B. Fatigue States: These are common to all persons under stressful circumstances. There is nothing pathological about being tired. On the contrary, it is a salutary experience, for it teaches one the need of rest. Any fatigue, physical, mental, or emotional, is the language of the self; self asks for rest and sleep. There is nothing quite so delightful as to be "dog tired" and lie down in a comfortable bed to pleasant dreams. Fatigue in itself is not a bad symptom, but many nervous children are taught by the words or example of neurotic parents to avoid fatigue as they would disease. "Be careful or you will get all tired out," or "you look terribly tired"—these expressions may make fatigue a fearsome thing in the mind of a child. Fatigue resulting from physical or other causes is another matter; it should be dealt with by the physician. It must be borne in mind that

fatigue may be a bodily matter and require medical care.

C. Sadness, Weepiness, Blues: These also are common experiences to all the human family. They come as the result of the sad, unhappy, and depressing experiences so common to all. There is nothing to worry about in normal sadness. But when that sadness remains longer than it should without "the sun returning after the rain," or when depression tends to become a fixed mood and joy and normal happiness fade out, it is time the thing be recognized as a wrong habit, and as a weak reaction. The real trouble with these depressed states comes when the child is beginning to be worried about them. He becomes worried over them when he comes to believe that they are getting beyond his control, that they have him in their grasp. To feel that one is the victim of a malign power always awakens fears. But the child must be taught the real nature of these darker states, and the mystery and fear of them must be removed. He must be taught to play, to laugh, and to have fun. It may be his tendency to become blue and discouraged, and he must be shown that it is his job in life to have a little more fun than other people and never to be worried when he is depressed, for it is impossible to avoid sad things in life. But he must avoid living too much with depressions and to counteract them with right pleasures.

D. Fears and Anxieties: Fear is a very useful emotion, for it saves people from many dangers such as hot wires, foul water, and reckless driving. But when fear has done its work of directing us away from danger, it should melt away and be forgotten. When fear remains in the attention until it seems hard to drive out, it has lost its value and has become a liability. The child who has developed a morbid fear has dwelt too long on a fear-experience, and he must get away from it. He has passed his threshold when a fear can no longer safely be retained. The child must be taught that it is not wise nor happy to dwell on his fears. He must form the habit of enjoying being without them. The morbid fears which develop into a state of anxiety must be faced, solved, and driven out. They may be driven out by understanding them and developing the habit of avoiding them; by direct frontal attack, that is, by mustering one's courage and overruling them; or by substituting for them other diverting interests, activities, and joys. The child must be trained in decision, in making up his mind and keeping it made up; he must work to build up courage, confidence, and nonchalance. He must form the habit of being decisive after he has carefully made up his mind as to the wisest course. The particular fear which troubles a child must be analyzed and explained away, but the main task is to develop a better reaction to life and its frightening things. If the child is brought to confidence in God, he can have

no great cursing fears or anxieties. He leaves himself in God's loving care. "If God is for me who can be against me?"

E. Night Terrors and Nightmares: It is for the physician to discriminate between these two forms of bad dreams. It is enough here to say that night terrors cause a child to awaken with a frightened start and in cold sweat. He remains awake an hour or so before he can return to sleep. Nightmares are merely terrifying dreams from which the child awakens with a cry, perhaps, without sweating and without remaining awake. These conditions are the result of too exciting a day or of some terrifying experience or daydream. They will be eliminated if the child has quieter days, more normal play, and a happier life. Both conditions may be the result of indiscretion in eating before going to bed. They are usually the mind's subconscious efforts to think out its dangers and perils during sleep.

F. Other Sleep Difficulties: Right conditions during the day will bring sound sleep to a normal child. Jittery, fearful parents will be more than likely to bring their poor sleeping habits to their children. A child should not be allowed to become sleep-conscious by hearing frequent conversations among his elders concerning their inability to sleep. A child should be allowed to grow up to take sleep as a matter of course, expecting to be wakeful when there is good reason for it, but normally

allowing sleeping to be as unconscious a process as breathing.

G. Bed Wetting: Enuresis, as the physicians call it, may have bodily causes which must be looked into by the physician. It should cease in the normal child, Leo Kanner says in his very careful discussion of the subject in *Child Psychiatry*, by the time he is three years of age. More boys are subject to it than girls, and it is not limited to any particular mental age. It is usually accompanied by other nervous symptoms, and as a consequence the child must be treated for his whole nervous condition. Kanner says that in his cases, eighty per cent had parents showing emotional instability or social maladjustment.³ The enuretic habit has a bad effect on the whole personality development of the child because of the feeling of incapacity it engenders, the fear of having some serious kidney or bladder condition, and wakefulness and worry over the condition. Dr. Kanner strongly advises against "shaming" and scolding or in any way humiliating the child in an effort to break the habit. It is in no sense intentional.

The treatment consists first of removing the sense of shame, of guilt, or of hopelessness concerning the condition, of doing away with bribing, and of endeavoring to improve unclean conditions in the home or in the personal habits of the child. It is usual to restrict or cut off all liquids after late afternoon. The voiding usually takes place at

³ Kanner, Leo, *Child Psychiatry*, p. 242, Springfield: C. C. Thomas.

about the same time each night. It is wise to wake the child each night before this time comes and send or take him to the toilet. This establishes the habit of waking when the desire to urinate is present. Rewards such as a "star chart" or the promise of a vacation trip when he has overcome the wetting habit are suggested by Dr. Kanner.

H. Masturbation: This is a mildly sullen and secret reaction to parental scolding, restraint, or punishment, or it may follow disappointment or other forms of hardship or frustration affecting the child. He turns to masturbation as a secret form of compensation for his hurt feelings or humiliation. It grows naturally out of the infantile exploration of the body and the finding of certain areas of pleasure. It may be learned from other children, of the child's age or older. Boys indulge in masturbation more than girls.

The child must be brought to see that it is a weak thing to do, that it demonstrates he is not exercising sufficient control over his acts, that it betrays a weak and uncontrolled personality. He must also be taught that it is not a matter of sin and guilt but of too much thinking about sex. The popular idea that it will lead to insanity must be cleared away, and he must recognize it as a common practise in youth. It is not anything which marks him as an exceptionally low grade individual. The best cure is to avoid sex thoughts and imaginings. Sex daydreams will always lead to it, and in moments of frustration or disappointment it is always likely

to occur. Medical investigations find that most boys and girls have practised it at some time, and often on into later years, especially in unmarried persons. The greatest harm is in the sense of guilt, the feeling of personal failure and incompetence, which it brings. Cleanliness and the elimination of sex daydreaming and imagining are the key to its elimination.

General Nervousness

I. Differentiation

(A) REAL NERVOUSNESS MUST NOT BE CONFUSED with the so-called nervousness of sound and normal people. Every person, after long continued strain, fatigue, hardship, or denial will be nervous in the sense of being jumpy, tense, irritable, and tired. These conditions, however, remain only so long as normal fatigue lasts. After rest and a good meal, resiliency, courage, and happiness return, and the person is ready and eager for the next fray. It is fatigue rather than nervousness.

(B) Nor is general nervousness to be confused with similar symptoms which appear as the result of toxic states, infections, and other bodily disorders. These need medical treatment.

(C) General nervousness is a condition appearing in persons with certain biological and constitutional tendencies, persons who are inadequate to living comfortably under the stresses and strains of life. They have an unstable psychological constitution, an inferior equipment with which to live.

II. The Complaint Problems

It is impossible to draw a neat picture of the complaints of these people. They are varied and compounded with other symptoms in such a way

that only general conditions seen in specific cases may be listed as the symptoms of the condition. Some of the more common complaints are:

A. Fatigability: This is probably as common a symptom as there is. Certain people have a low fatigue point; they cannot endure what their general condition indicates they should. Not only extra exertion, work, play, or routine life wearies them unduly but also the little things wear them out. It is often seen among clergy who feel that their Sunday work leaves them "done up," that Monday, "blue Monday," is a day of rest for them, and that they must be found in bed until ten o'clock. A service may weaken them until they are cross and irritable and demand quiet and rest for the remainder of the day. They have accepted the solicitous sympathy of some kind women, to be found in every congregation, who continually say to them, "You must be so tired. Your work must be so exhausting!" and have come to believe it. It is found in men and women who feel that the daily grind of monotonous existence is wearing them down and that they must give up and rest. It may be that a wife or mother has habitually suggested to one that he must be careful or he will get all tired out; he has accepted that philosophy of life. He does not realize that to become really tired is necessary to having a delightful night's rest. But fatigue may come from deeper personality inadequacies. It may be that the memory of being jittery

and unable to sleep has become fixed in the mind and he cannot forget the feeling of fatigue. He is looking into his feelings to see if he feels fatigue because he has a fear of it. It may be a fear of mental fatigue, a fear of thinking hard, of studying hard, or of trying to think out some "deep" subject. Such a weakness is accepted as a fact and hard thinking is avoided. But a fatigue state, physical and/or mental, may follow the ordinary thinking of the day. It may take the form of organ fatigue, the feeling that the digestive functions are below par because of their tired state, or that the heart functions poorly because of the same reason. And the emotional tone of a fatigued person does, of course, affect the tone of the bodily organs, as we have seen.

B. Inability to Carry Responsibility: Responsibility may be too wearing for the nervous person, and as a result he will avoid a promotion or grumble and complain because of the heavy load of the responsibility he feels he is carrying, while a normal person may feel that he has no such great responsibility in his life whatever. It is but his nervous reaction to the idea of responsibility.

C. Inability to Be Rushed: It is a characteristic of the nervous make-up that the person is likely to become confused or worried if pushed beyond his usual speed. He must go his own gait. If he is hurried he may become tense and agitated and confused; he may reveal an intellectual or emotional instability and may quit his job and get back

to his own speed or else develop other nervous symptoms.

D. Over-activity: With the slow-speed nature there is often a compensatory sort of quickness of movement, a restlessness, and a lack of repose which is quite out of keeping with a slow thinking, deliberate-acting person. It may be either a conscious or unconscious effort to make up for the slowness he recognizes in himself, but it is muscular activity only and not expressive of any real purpose.

E. Weak Emotional Control: Emotional instability, the faculty of weeping or of feeling gay without sufficient reason, is a characteristic. To weep at the thought of another's sadness, as when reading of it in a novel or seeing it in a movie, is an expression of the person's own grief released through these experiences. It indicates a deep wound, repressed but ever present. Anger uncontrolled also shows a lack of control over emotions, but it is a release of an emotion which does not seem so "weak" as to give up to tears.

F. Speech Disorders: Disorders of speech such as stuttering and stammering are most common in children. Self-consciousness in speaking, giving rise to uncertainty, bashfulness, and silence, is a familiar symptom.

G. Temper Tantrums: Tantrums, in which the individual lets go and surrenders to the passions of the moment and is voluntarily possessed by temper, are characteristic. It is an awkward attempt

to impose one's own self upon others and win the contest of wills by all-out anger, though it is not consciously determined.

H. Tremors, Twitchings, Tics, and Occupational Cramps: These motor neuroses may appear in general nervousness, though they are classified under hysterical reactions where they appear as more important symptoms. A fine tremor, awkward and jerky movements, and gait all betray tension and nervousness.

I. Gastric Disturbances: Indigestion, fussiness in eating, gas, constipation, or diarrhea affect many nervous people. It is upon them that the advertisers of health foods and cathartics thrive. The emotional reactions of nervous people necessarily produce dysfunctioning in the digestive system, and these conditions are sometimes blamed for the nervousness.

J. Sweat and Skin Disturbances: Cold sweat and blotches on the skin result from this condition. Eczema is often caused by it.

K. Unstable Heart Action: The heart may pound, as while under the influence of strenuous physical effort, or it may lose a beat, producing in the nervous person a fear of serious heart disease. This is particularly true in an age of special interest in heart trouble and the fear of it.

L. Fearfulness and Anxiety: These usually accompany the other symptoms of this disorder, though there may be no actual grounds for the fear. It is a vague and general fear that something

is dreadfully wrong, or a foreboding of what the future holds in store. It is this state which drives the neurasthenic person to seek help. The condition becomes serious to him.

M. Uneven Performance: The person in this condition shows great variations in all his functioning. Sometimes he is at his best, while at other times he functions poorly. There is no even tenor of his ways; he fluctuates between up and down.

N. Tension: This is a constant symptom. The person is bodily and mentally tense and finds it difficult to relax. The symptom can be seen in his movements and his gait. Attention is intensely fixed upon his symptoms and it is hard to "drop it," to "forget it."

All these symptoms may be intermittent or prolonged. They may be replaced by others, and they may appear in all sorts of combinations. The pure, single-reaction form of such a nervous disorder is hard to find.

III. The History of the Complaints

In studying a nervous disorder, it is best to begin with the present condition and work back to the underlying causes. Here is a certain condition; how did it come to be what it is and under what circumstances? When the condition has become troublesome enough for the person to seek or to welcome help, something has occurred to make it seem more serious. What has happened? The

answer may be found in a shock, a strain, a frustration, or some such experience. This experience represents the limits of the resistance of the person, it marks his bending point. It will be such a trial as is heavily charged with emotion, the repetition of some long-continued effort, the tiresome monotony of everyday living, failure in some form, being misunderstood, denial, or hardship. It is such experiences of strain and stress which bring to light the constitutional limitations of the nervous individual.

IV. The Personal History

In the study of the past life of the person it will be found that he has shown from infancy an unstable make-up. His earliest recollections may often reveal his deep longing for something he does not have, or they may express his sense of being what he does not want to be. His earliest history will show the sort of thing which brings uneasiness and unhappiness into his spirit. He feels his inadequacy and his constitutional defects; and this finds expression in his fearfulness, his exasperation, and his unhappy feelings. The fact that he is of this nervous temperament will be evident in the more important experiences of his life and in his reactions to them. What were the frights, the fears, the shocks, the denials of his life, and how did he meet them? What sort of a personality did he build up?

It is important that the formation of his per-

sonality be not considered as volitional. Few of us become what we are to any extent by personal effort and careful planning. The nervous person becomes such and reacts as he does in spite of himself. He reacts largely in an automatic way to the stimuli of life's circumstances, and his personality is formed according to its own bent. He is largely made, up to the present, by what he was born with and by the influences which have pressed upon him. The study of his personal history is made to determine just what his reaction type is and what influences have had most to do with producing him. It is this which makes a person a mystery to himself and makes it difficult for him to rectify his life without outside help.

V. The Family History

Another factor which must be understood is the sort of bent which his family and his particular home life gave him. Here is the underlying outside influence which has made him what he is. Did he have nervous, anxious, and worried parents? Were his mother or his father or both nervous? How much does the child reflect their reactions to life? The parents may have never really understood the child, they may have encouraged him to hedge his life about with self-imposed limitations, they may not have taught him either by word or by example to face life and make the best of it. They may have encouraged a hurt, a peevish, or a surrendered

attitude toward hard things. It may be that friction in the family, quarreling between the father and mother, alcoholism, shocking conduct before the child, a broken home with its broken loves and responsibilities, and all other forms of wrong conduct entered into producing the nervous child and man. Adler taught, and quite wisely, that either a pampering or a harsh or cold method of treatment of children alike produce or help to produce nervous conditions. Unloving parents leave the child bereft of a long list of blessings every child has a right to expect in life.

VI. The Formulation of the Problem

When these facts have been studied sufficiently to make a clear picture of what the reaction pattern of the nervous person is, and what the influences are which have borne upon him and have developed him into his present unsatisfactory self, they must be carefully formulated by the pastor. He must come to see the "whys and hows" of the nervous condition he is studying.

When the formulation is satisfactorily completed, it is necessary to begin the process, sometimes brief and again prolonged, of revealing the facts to the nervous person. He must be brought to see himself as he is and how he became so. The situation must be formulated for him until he has a complete grasp of it. Arguing, scolding, or insisting must not enter into it, but he must be led to

see it for himself. It is a true process of educating the individual.

VII. The Plan of Treatment

The plan must make it possible for the patient to understand just what he is to do to build his house on solid rock. Whatever is wrong in his environment that may be changed should be. This is often difficult. Sometimes he may be moved out of his environment and into a better one, but it is often very difficult for a person to make radical changes in his life when he has to consider his family. He must be taught to live slowly and to avoid speeding up. Fast work must be avoided, and his life must be cast in a type of work which permits him to live his best. He must learn to control his emotional life and to build up new emotional reactions. His excitability must be watched and the quiet, happy things stressed. He must be taught the folly of spending his time and money shopping about among the doctors, looking for some panacea for his ills, and must come to see that his medicine is within himself. He must be brought to see that he is entitled to pleasure and the happy things in life and that he must plan to enjoy them. His various symptoms must be dealt with as fully as necessary and then dropped from the conversation after he has come to see that they will disappear when he has re-established his life on a better basis—with better reactions to life's problems and trials.

VIII. Religion

No nervous person is free from the danger of lapsing into his neuroticisms until he has that to hold to which religion alone provides. He must learn to gain a companionship with God which makes him feel right with the universe; he must get that goal and aim in life which only obeying and pleasing God gives him both in himself and in his relations to others. With this keeping in the presence of the best he will be able to gain the faith which he so seriously lacks. Beginning with friendship with God, he goes on to the strong confident life. "Perfect love casts out fear."

IX. The Prognosis

The future of a general nervous person is very hopeful. When he has learned to react as a normal person should, within his limitations which he must frankly face and accept, he can be brought to live a comfortable and happy life.

Tension and Irritable-Weakness States

I. Differentiation

IN 1880 TENSION AND IRRITABLE WEAKNESS STATES were described and named by an American physician, G. M. Beard. The theory was, and it was later developed by Dr. Wier Mitchell, that it was the result of a weakening of the neuron system. It was named accordingly *neurasthenia*, or nerve weakness. More recent neurological studies have, however, disproved the theory. In Europe it was formerly called the "great American Disease," because, as one English physician said, "all Americans have it." This is of course not the fact, for it is an old disorder, only identified and named in recent years.

This condition is not to be confused with nervous states resulting from organogenic, neurogenic, or exogenic conditions, nor is it the result of fatigue states. These conditions are to be medically or otherwise treated and cured, while *neurasthenia* is of psychic origin and is to be treated psychically.

The name given to these disorders by Meyer, tension and irritable-weakness states, is exact and inclusive, though the term *neurasthenia* is still used on occasion for brevity.

II. The Complaint Problems

In general, the symptoms are more severe than those of general nervousness. They go deeper and are harder to eradicate, and they often have in them the beginnings of even worse forms of psychoneurotic states.

A. Tension: To use Meyer's words, first comes tension. The person with this condition is always strained and worried. Under pressure and strain, he experiences various other symptoms as a result of the tenseness. Muscular tenseness of the neck muscles produces neck ache, stiffness or fullness at the back of the head, headaches, strange feelings of the head. Tension of the abdominal muscles can check peristaltic action and result in "indigestion," gas, and headaches. Mental tension as the result of intense and prolonged distressful thinking leads to fears and anxiety.

B. Irritability: Not only the words and acts of others irritate him but also his whole situation, his fears and anxieties, his bad feelings, and his limitations because of his nervousness—all tend to make him irritable.

C. Weakness: The weakness of general nervousness is very great. The patient is weak in body to the point of prostration. After an effort to do some simple thing he fears, such as walking around the block alone, he may return to his home to throw himself upon the floor in complete exhaustion. The

weakness is also attributed to such organs as the heart and stomach, and he is tormented with the sense that they are hardly able to carry on their proper functions. His mentation is weak; he finds it hard to concentrate. His emotions also share the weakness.

These three words therefore give the basic picture of the sufferer from this disorder. Other symptoms develop as the following will indicate.

D. Headache, Head Pressure, and Various Bodily Aches and Pains: Headache and head pressure will result in a well person from a disordered digestive system, but a nervous person will be extremely sensitive to them. They may worry him with the idea that there is something wrong with his brain, thus producing added causes of fright and anxiety. The bodily pains, if not resulting from any physiogenic cause, are more or less normal pains due to bodily dysfunctioning, but they assume serious proportions to the patient.

E. Gastric, Secretory, and Intestinal Variations: These proceed from the emotional state of the patient, working through the nerves controlling the organic functions. They may suggest to the patient, and even to a physician, peptic ulcer or appendicitis, and many operations have been performed in the past through such a diagnosis. The patient will be worried and troubled by the pains and will often resort to the drug store in search of remedies. The habit of "medicine eating" may result.

F. Cardio-Vascular Irregularities: The irregularities of heart beats, poundings of the heart, or other passing sensations arouse deep fright in these patients, though the clinical tests of the heart are entirely negative. Whatever the doctor says, the irregularities are there, the patient feels, and it takes more than the statement that his heart is sound to cure the condition. The irregularities are the results of his nervous condition and not the cause, in the case of true neurasthenia.

G. Urinary Frequency: The bladder-kidney functionings are also affected by the fears and other emotions of these psychoneurotics. The desire to go often to the toilet and the sense of urgency are parts of the same result of nervousness. He may develop the fear that the kidneys or bladder are in a diseased state.

H. Menstrual Irregularities: These also are psychically caused. A time of unusual nervousness and excitement, with fear and anxiety, will alter the menstrual function, reducing and also checking the flow. Many women are in a state of unusual nervousness at these times, weepiness and irritability coming without any adequate cause except the physiological effects of the periods which bring on the slump.

I. Neurogenous Skin Affections: Blotches on the skin and eczema also are symptoms.

J. Other Organic Dysfunctioning: This may be attributed by the patient to the bowels, because of constipation or slight diarrhea; or to the sex

organs, because of sexual weakness; or "spinal," because of backache. The patient may worry about his sight or his hearing also.

K. Depression: Depression over his condition may result. This depression must of course be carefully studied by a psychiatrist, if it is serious, because it may be the beginning of a major depression. Dr. Esther Loring Richards gives a statement which may be of service to the pastor without access to a psychiatrist. She says: "Suspicion of the latter [a major depression] is aroused by marked reduction in sleep, loss of appetite, loss of weight, persistent and real difficulty in concentration, as indicated by tests of intellectual functioning and a history of inability to concentrate on the day's work. The patient's own statement of a depressed mood with self-accusations, and a mood that starts the day with gloom and lightens as the day goes on, should make the physician extremely cautious with regard to diagnosing a psychoneurotic process."¹ Where these conditions do not maintain and the depression is more in the nature of passing blues, the condition is probably psychoneurotic.

L. Special Fears: There may be symptoms of other fears, such as the fear of losing the mind, of becoming an invalid, or of becoming incapable of carrying on the day's work in the future. Unless these symptoms are strongly marked and very

¹ Richards, Esther Loring, *Introduction to Psychobiology and Psychiatry*, p. 166. St. Louis: C. V. Mosby. Used by permission.

insistent, they are probably the accompaniments of a psychoneurotic condition.

III. The History of the Complaints

The question here again is to discover what precipitated the present illness. What experiences marked the deepening of the condition or the onset of his present distress? Something in the nature of an illness, a shock, a fright, a strain, or a fear has been the immediate cause of the trouble. Not that the cause itself is of great importance, but it must be understood in order to orient the pastor and later the patient to the development of his illness.

IV. The Personal History

The study of the individual's past life, his experiences which may have had a bearing on his condition, and his reactions to them, are all of great importance. They will reveal a nervous make-up and a history of meeting his hardships with weak and wrong reactions. He will show a lack of resiliency, a lifelong fatigability. His comeback will be found to be slow and uncertain. He requires considerable time to get over his bumps, and he will always require much sleep. Disappointments will loom large to him; he will be introspective and moody. His tendency to feel that he is always below par will be marked, as will his courage in facing the future and all the hard things which come his

way. He will reveal a constitutional weakness of reaction, an inability to meet life with the fortitude which should belong to him as much as the color of his eyes. He does not properly see himself as he is, and he has never found out how to make the fullest use of his possibilities. It is the result of this poor reacting to life which has made it possible to accept his various symptoms as substitutes for the real personality defects he does not understand.

Again, it must be said that he is not malingering or purposely deceiving himself or his friends; and scolding, telling him to "snap out of it," or ridicule hurt rather than help. He is, as Dr. Richards so well says, "doing the best he can," but he needs help and enlightened guidance.

V. The Family History

Much of the misery of his condition, perhaps all of it, can be understood when one looks into his family background. The nervousness in father or mother, or both, aggravating and wearing conditions in the home, friction between the members of the household, and the family's inability to understand the psychoneurotic person—all these help to explain his trouble. He has been poorly trained, he has lacked the proper disciplining of life, and he has never caught the idea of a strong, resilient life such as he really ought to live. Perhaps he has a temperament which finds no sympathy in the home, its ideals are not his ideals; he has been the wrong

person for the home. The home may have lacked the peace and quiet, the slow movement, and the normal happinesses of home life which would have helped him to form himself into a different person. Alcoholism or sex problems in the home and in the life of the psychoneurotic may have added to his discomfort. Sickness, general ill health, an operation, or a physical handicap may have been present in the past which later bore its fruit. Any abnormal condition, any sort of wrong life, may have given rise to a sense of failure or of guilt which the family life added to his trouble.

VI. The Formulation of the Problem

This careful statement of all the evidence in the case and the summary of how it affected the patient is necessary before a plan for his readjustment to life can be made. It should be put in a brief summary at the close of the record of the study of the case.

VII. The Plan of Treatment

The plan for the treatment of the case should never be made final and unchangeable. There must always be left a loop hole for further facts which may throw new light on the case but which may come up after the analysis is completed. The plan includes the giving of the formulation of the case and a definite statement of the several things to be done in order to bring the patient back to normal

reactions, so far as he can make them normal. It must all be within the patient's grasp and willingly assented to. He must be encouraged with assurance that he can re-orient his life and become the man he wants to be.

VIII. Religion

The same technique should be used here. The patient should be shown that religion is not an alien thing, or irrelevant, but that it brings to him just the three things he has lacked in the past. The psychiatric study and treatment are really but the scientific way of expressing the right life and how to attain it. Now he is ready for the right life, as such.

IX. The Prognosis

Two or three months of semi-weekly interviews, of not more than three quarters of an hour, should be sufficient to make a new man of the victim of this form of nervous disorder. He may have been forming his wrong reactions all his life, but there seems to be the natural urge to the right life within him to help him back to normalcy. The development of a psychoneurotic life is constantly a movement against the grain. It is because of this that he can correct in a few months or even weeks what it has taken years to acquire.

9

Anxiety States and Disorders of Anticipation

I. Differentiation

ANXIETY STATES AND DISORDERS OF ANTICIPATION ARE often forerunners of major depressions or of some other psychosis. The pastor should be very careful that such is not the case.

These conditions may also result from bodily disease where medical treatment is necessary.

Hyperthyroidism produces a similar condition, though there are certain differences. This is again another reason for having a careful medical examination before treating patients.

II. The Complaints

A. Attacks: This is usually an attack disorder, differing from a chronic state of blues by the sudden and intense anxiety which comes without special reasons. The attacks may remain for a few seconds or for an hour. The attack takes the form of a frightening sense of foreboding, of feeling that something dreadful is going to happen. It is accompanied by special symptoms, as described later, and the patient is startled by his sudden and apparently dangerous condition. His family is as frightened as he, and the doctor may be called. Even he may be alarmed. The attack may come at any

unexpected time, while in ordinary conversation, at meals, or in the night. When the attack passes, as suddenly as it comes, the patient is left as normal as he was before, except for a quite natural fear of the recurrence of the attack. There is little that is standardized about these attacks, they vary in every way with each individual, as to details. Only the general pattern is the same. They often appear as parts of other psychoneurotic disorders or as new and terrifying symptoms.

B. Tension: Billings says, "Anxiety states or syndromes always occur in an individual who is tense and uneasy."¹ It is a tension with an anxious, expectant mood accompanying it. The patient does not relax but is tense because he is waiting for something. There is always a fear that something very terrible is about to happen; it may be the next attack or possibly some vague and indefinable frightening experience.

The forms the attacks take are:

1. **DIFFICULTY IN BREATHING:** In some form the patient suddenly finds himself unable to breathe, he feels he is choking, a weight is upon his chest, or his breathing muscles refuse to function.

2. **HEART IRREGULARITIES:** The heart may pound, skip, flutter, race, or drop a beat or so. There may be a feeling of pressure on the heart, a pain, or shortness of breath, and a gasping for breath while the attack remains. It is a condition which quite

¹ Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*, New York: Macmillan. Used by permission.

naturally frightens the family, and this in turn increases the fright of the patient.

3. PERSPIRATION: Cold sweat stands out on the patient's face as a result of his fright over his condition.

4. VERTIGO: This is "of a subjective type." The patient experiences it as dizziness or feeling faint.

5. GASTRO-INTESTINAL COMPLAINTS: Gas, loss of appetite, nausea, etc.

6. FEELING OF WEAKNESS.

7. OTHER SYMPTOMS: Various other symptoms of different kinds of nervous disorders, which may be associated with anxiety attacks, occur, such as dry mouth, cold hands or feet, clammy skin, inability to keep warm, irritability, restlessness, and uneasiness.

III. The History of the Complaints

The immediate cause may possibly be found without trouble—some recent experience awakened the whole latent capacity to be anxious. Some hard thing the patient has undergone, or anticipated going through. But usually the immediate cause is not so easily found, for the condition grows out of the whole preparation for such attacks by the person's habitual reaction to his disappointments, strains, and hardships. It may result from sex stimulation without adequate satisfaction, or from long anticipation of some particular "breakdown" in his body. His personality make-up was gradually built up over the years, and he had become conditioned

for anxiety before it came. He is worried, becomes tired easily, has difficulty in sleeping, has a "tight" pain in the head; he feels that it is hard to concentrate and "practically always" feels cold and cannot get warm enough. All this is in the background of an anxiety psychoneurotic person, but the actual cause of the coming of the attack is, if it can be identified, something trivial and of little real significance. Dr. Billings says that "patients with such disorders constitute a large number of the cases treated in general practise as indigestion, peptic ulcer, functional cardiacs, suspected tuberculosis, suspected undulant fever, and thyroid dyscrasies."² There may have been an attack of flu or some other debilitating disease which paved the way for the anxiety condition.

IV. The Personal History

The patient has a history of constitutional deficiencies, intellectual and emotional instability, and a psychoneurotic personality. Hardships, guilt, humiliation, and thwarting have been reacted to in wrong ways. He has been poorly endowed with resiliency and self-forgetfulness.

V. The Family History

Here again will be found the story of a child growing up in an atmosphere charged with nerv-

² *Ibid.*, p. 114.

ousness, misunderstanding, and friction. Nothing has been given to the child in the home to enable him to look life in the eye as its master.

VI. The Formulation and the Plan

The formulation is that of the familiar picture of the development of a psychoneurosis. He must be shown what his particular trend is and how he has developed an anxious, apprehensive attitude toward the hard things of life. He makes things harder for himself by dwelling fearfully upon the things which, whether rightly or wrongly, make him anxious. He must train himself to a more resilient attitude—more courageous and more confident. The habit of thinking anxiously must be replaced by the habit of quickly dismissing the fearsome thinking to which he has trained himself in the past. He must be brought to know how to control those things in his life which have brought him the miseries of an anxiety neurosis.

VII. The Prognosis

These conditions are not particularly difficult to clear up, if the problem involved is psychoneurotic. A few weeks may be all that is necessary to put him on the right path. One educated man of thirty who had developed the well-defined pattern of an anxiety neurosis was adjusted to life in one interview. Another case might have taken a month or so. It is

of course impossible to attempt to prophesy how long it will take in any given case, and it is never wise even to guess. It depends both upon the wisdom of the pastor and the response of the patient.

*Dissociative-Dysmnesic, Substitutive
Phenomena*

I. Differentiation

DISSOCIATIVE-DYSMNESIC, SUBSTITUTIVE PHENOMENA is commonly called hysteria, but that word is so loaded with wrong meanings and is so wrong in its etymological sense that it is well to avoid it except occasionally in the interest of brevity. The word comes from the Greek *usterion*, womb. Formerly it was considered a disease having its origin in the womb; but though there are five times as many women as men with this condition, men do also have it.

It must be carefully set apart from more serious conditions, for it is present in thirty per cent of all psychotic individuals. It is also true that when it is present in a major reaction, the psychosis can be identified as such. But the pastor should have psychiatric direction before being sure such a person is truly a psychoneurotic.

It may also be confused with the symptoms of *petite mal*, incipient epilepsy, and this again requires a psychiatric examination. If the case is one of neurotic form, it may be accepted by the pastor.

II. The Complaint Problems

The complaints of hysterical patients are protean. They may simulate any disease known to man. It is commonly spoken of as an escape disorder, a "flight from reality." This does not in any sense imply a wilful, purposeful escape from reality, for the patient is not conscious of the why of his disorder. But an unconscious substitution is made, and the substituted condition has many of the earmarks of the real thing. No complete list of such symptoms of hysteria, substituted conditions, can be made because of their infinite variety. But some of the more typical are here set down.

A. Muscle Contractures: Muscle contractures, twitchings, jerking, and tics, commonly called motor neuroses. These are noticeable in the person's gait, in his playing with his face, the face muscles themselves, the jerking of a shoulder as though the collar did not fit, the jerking of the head, raising the eyebrows, blinking the eyes, and similar purposeless habit movements. They are formed by frequent and habitual use, and in the beginning they may have begun with some temporary physical need which afforded certain satisfaction in their performance. They have become automatic through use; and the satisfaction to the personality continues, though the physical need has passed. They take place when the person is in a state of tension, but while in repose they become relatively inactive. Writer's cramp or occupational

cramps are similar reactions resulting from tension and from a habit which is only partly consciously performed.

B. Simulated Paralysis: There is an inability to use a limb which is much like paralysis. The limb may be in a dormant state or twisted out of normal position.

C. Anesthesias: Certain areas may become without sensibility. It is usual that such anesthesias are delimited by sharp lines of demarcation, such as glove or stocking anesthesia.

D. Simulated Blindness, Deafness: Simulated blindness or deafness, where those organs seem to cease to function or function only partially.

E. Inability to Swallow: Apparent paralysis of the throat muscles.

F. Losses of Memory: Losses of memory in certain areas as though certain experiences, very repugnant to the patient, are forgotten, while other experiences are clearly in consciousness. Amnesia is a form of this disorder, as also are "split personalities," though these are psychiatric problems.

G. Delirium: This may also be an hysterical form.

H. Epileptoid Seizures: These simulate epilepsy but in some ways are not the same as true epilepsy. An hysterical epilepsy will not result in injury to the patient as he falls, for there is always a certain consciousness behind these conditions. Nevertheless, the simulations of epilepsy are so real as to be confusing.

I. Emotional Outbreaks: Tantrums also may be of an hysterical nature.

III. The History of the Complaints

The attacks of this disorder come suddenly and without warning. There will be found a history of what the individual feels were bitter experiences which he tried by every possible means to avoid. The hysteria itself comes without warning and without premonitory symptoms, but though he complains of it he feels that it is not so bad as it might be. In fact, he derives a sort of interest or pride concerning it, and he talks of it quite freely and naturally. The patient has not lost weight, he seems to be in good health even though he may be sure he has a serious heart condition. But back of the present condition there lies the story of an hysterical type. It will come out in the investigation into his personal history.

IV. The Personal History

As a child, the hysterical person sought affection and sympathy; he wanted to hear words of appreciation and kindness. If he did not have this sort of treatment, if he received what he disliked in the way of treatment, he was inclined to avoid the unpleasant situation by some sort of escape from it. He would not stand and fight. The hysterical person has always been spoken of as an escapist. Whatever

hardships, disappointments, and misfortunes he has had to face, he finds a way to avoid direct conflict and makes some sort of an escape from the realities of the situation. He is inclined to live in a world of fantasy, of unreality, and make-believe. These are means of forgetting or shutting out the unpleasant realities. He is suggestible and readily picks up ideas and imaginings, which become very real to him. He has a real ability to shut out the facts by believing in something unreal, perhaps something unwittingly suggested to him in conversation. He plays with the idea of some special illness, and in his imagination it is very real. This may explain the strange simulations of diseases, for at first blush there is a more or less conscious flight into sickness as an escape from the dreaded reality. Later illness becomes to the patient a reality instead of a simulation. He cannot be blamed for fraud or for consciously malingering. Flighty in thought and emotion, he has landed in a false position which has become true to him.

Special symptoms in the person under investigation may be differentiated from definitely physiological conditions by various methods. Headaches of the nature of migraine, and perhaps migraine itself, have the periodicity, the character, and the emotional causes which are characteristic of this disorder, and these may be entirely hysterical. Anesthesias are marked by definite lines of demarcation which a physician can tell by the sensory innervation of the area; that is, hysterical anas-

thesias do not conform to the distribution of nerves in a given area. The inability to stand or walk, or to get out of bed; palsies, tremors of many varieties, simulations of chorea or St. Vitus Dance, occupational cramps, tension, hyperactivity, are frequent landing places of these patients in their flight from reality even though they show no signs of bodily diseases. Probably the most alarming symptom, to friends, are the epileptoid seizures, without evidence of neurophysiologic disharmony, with falling but no injury to the patient. These conditions, however, along with cataleptic seizures, stupors, dual personalities, and amnesias are problems for the trained psychiatrist and not for the pastor, even though these may be purely hysterical episodes.

V. The Family History

The family may be of value in throwing light on the patient's history in many ways, though the patient may be entirely a mystery to them. From them may be secured such facts as the following: flighty tendencies of the patient's thinking and feeling, his craving for praise and recognition and love; his face's always lighting up, as he narrates his little successes and recognitions. These patients may be recognized as actors playing a part, they are sometimes self-centered and selfish, and they may at times take refuge in something disagreeable rather than meet life squarely. They may be inclined to be critical of their friends and family.

VI. The Formulation of the Problem

The formulation of the patient's situation must be centered upon the escape reaction trend of the person, upon his habit of dodging hard reality and of seeking another way out. He must be brought to see his substitutive reaction tendency, his faculty of losing himself in the imagined unrealities until they seem to him to be realities. He must come to see that he must be willing to be human, to face and conquer life rather than avoid it, and to develop a resistance both to hard experiences and to his escapist trends. He must be shown that it is not mere stubbornness, wilfulness, or intentional dodging of life which troubles him but a very annoying gift of accepting some substitute for real life, for life as it is. His thinking processes have confused and misled him, and it is these which must be rectified. He must have explained to him the hows and whys of his reactions. His history will illustrate these facts.

He must come to understand the unreality of the substitutes and their real meaning to him, and he must learn how to avoid them.

VII. The Plan of Treatment

The plan for bringing the patient into the right way of living must be adapted to his particular problems. The underlying personality defects must be brought to light and definite procedure given

him to replace the defects with normal reactions.

As in every other psychoneurosis, a strong and satisfying life with, for, and from God will be the most powerful means of his re-orientation.

VIII. Prognosis

The prognosis is usually good in psychoneurotic hysteria. It may require from a few weeks to several months to remove the symptoms and establish the patient on a sound basis of adequate adjustment to life.

Hypochondriasis

I. Differentiation

THE GENERAL CHARACTERISTIC OF HYPOCHONDRIASIS is that of chronic invalidism. The patient is preoccupied by physical complaints which he attributes to medically sound organs, or the exaggeration of minor and unimportant physical defects.

This condition may be confused with the manifestations of schizophrenia, paranoid depression, or an involutional condition. Moreover, these states are very difficult to treat, and collaboration with a psychiatrist is essential. With proper guidance from him, it is possible for the pastor to accomplish good results.

II. The Complaint Problems

(A) In general, the complaints are those of invalidism, soundly fixed belief in certain physical disorders related to organs which are controlled by the autonomic nervous system and under the influence of strong emotion. The physician's examination will reveal no organic or structural defects in a genuinely psychoneurotic hypochondria: The organs thus affected will include the stomach, the bowels, liver, reproductive organs,

muscle groups, the heart, and some nervous systems.

(B) Dr. Richards lists characteristic symptoms as, "headache, vertigo, general weakness, nausea, vomiting, abdominal discomfort, belching, acid stomach, constipation or diarrhea, anorexia, general pains, burning sensations over the body, insomnia, profuse perspiration, backache, quivering, shaky feelings, numbness."¹ To this list may be added chronic indigestion, bad heart conditions, the conviction that he has tuberculosis or a cancer of the stomach, weakness of the eyes, ears, or throat.

III. The History of the Complaint

These people are inordinately body-conscious. Their life-long pre-occupation with the body and its functions has grown steadily. It is not a sudden development. The patient has long ago accepted the bodily disorders of which he complains, and he gives his attention to watching them develop.

IV. The Personal History

Behind the complaint symptoms lies, in these persons, a personality which is insecure, particularly in the matter of bodily health. His various experiences have, in his particular personality, given rise to concern about his health and his organ

¹ Richards, Esther Loring, *Introduction to Psychobiology and Psychiatry*, St. Louis: C. V. Mosby. Used by permission.

functioning. He is suggestible. He has spent much of his thinking in pondering over his hereditary trends and weaknesses, and he has absorbed the half-knowledge or ignorance of friends and has attempted to incorporate it all into his convictions regarding his body. He has a special type of personality which is peculiarly sensitive to physical ills. Again, the disappointments and trials of life have caused their reactions, in the hypochondriac's case, to bodily disease. He feels the tension and unrest which follow hard experiences and attributes them to an illness. Sometimes hysterical and anxiety trends are found. These contribute to his ailing condition.

V. The Family History

A family which has hypochondriacal tendencies and is unduly exercised over bodily health may contribute much to the patient's condition. His suggestibility makes him unusually receptive to every morbid idea the family may have, and he gathers them all together for himself. The family, not understanding the hypochondriacal trend of the individual, has done nothing to counteract the influences. It may even be that a physician has given him food for dark thinking by an inadvertent remark. Too much medical attention may fix in the hypochondriacal person's mind the distressing conditions which seem to make him an invalid. Unnecessary operations will have the same result.

VI. The Formulation of the Problem

A careful and thorough study of the personal organization of the ill person should make it possible to determine how the present illness fits into the picture of his maladjustment to life. This picture is a difficult one to secure, but it is altogether necessary to any accurate formulation of the condition. If it is difficult to secure, it is much more difficult to impart it to the patient. Long and persistent effort are required before the process brings results. In fact, Dr. Billings says that "the real essence of treating this type of disorder is in preventing it."² That is it must be met in the child and there dealt with intelligently, by doing everything to change the wrong home conditions which give the child an over-concern for his body, by training the child to think normally concerning bodily ills, and by surrounding him with normal and healthy activities.

Religion is of the same value here as in other psychoneuroses. No hypochondriac is safe and secure without it.

VII. The Prognosis

The process of adjusting these patients to life is a long one. It requires great patience, perseverance, and tact. It may take a few months to effect the re-education, or it may require two or three years.

² Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*, New York: Macmillan. Used by permission.

Obsessive-Compulsive-Ruminative Tension States

I. Differentiation

(A) OBSESSIVE-COMPULSIVE-RUMINATIVE TENSION states are the most serious of all the psychoneuroses, so much so that the writer must repeat Dr. Billings' remark: "In general, it can be safely said that the obsessive-compulsive-ruminative tension states, in contradistinction to some of the other disorders of personality, are therefore therapeutic problems for the psychiatric specialist."¹ The pastor's part should be limited to that which has been delegated to him by the psychiatrist. If there is not a psychiatrist within reach, geographically or financially, it may be necessary for the pastor to do what he can for such persons.

(B) This condition may be a major depression or schizophrenia. Oscar Diethelm² says that if the condition occurs for the first time in persons over thirty years of age, an organic reaction must always be considered. Dr. Billings says he has found that thirty-one per cent of his cases were men and sixty-nine per cent women. The danger of this condition's being a seriously psychotic one takes diag-

¹ Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*, p. 133, New York: Macmillan. Used by permission.

² Diethelm, Oscar, *Treatment in Psychiatry*, New York: Macmillan.

nosis and treatment out of the field of the pastor, except as an emergency matter.

II. The Complaint Problems

To begin with Dr. Meyer's name for this condition, examining each of the words seriatim:

A. Obsession: An obsession is a recurring idea out of control and alien to the individual, which he recognizes as illogical but which he cannot keep out of his thoughts. It is an idea upon which the attention is fixed, and it is extremely difficult for the patient to let it go. He will be diverted momentarily and will think dully of other things, but in a moment his thought and words are focussed upon it again. He knows it is foolish and that he ought to settle and drop it, but he cannot. Among the ideas held in this way are doubts of anything, and particularly himself; superstitions will not leave his mind, he broods upon those which hold him—a misfortune or mistake in his past life, upon which he constantly dwells. There is a long list of named fears which having reached the obsessive point are called phobias. They include such fixed fears as:

(1) Agrophobia, the fear of open places, of being in a crowd.

(2) Claustrophobia, the fear of closed places, of being shut in or locked in.

(3) Mysophobia, the fear of dirt, of bacteria and infection.

- (4) Thanophobia, the fear of death.
- (5) The fear of taking the life of a child.
- (6) The fear of suicide.
- (7) The fear of losing one's mind.
- (8) The fear of acting queerly, of having a fit, of fainting.
- (9) The fear of losing control of self.
- (10) The fear of "vulgar thoughts."

B. Compulsions: A compulsion is a recurring idea, out of control, to do something unnatural and unreal and silly. Foolish repetition of acts such as washing hands, locking the door, rituals of dressing, using certain words. These differ from delusions in that in these the patient struggles against them, in delusions they struggle with them. Many of these are familiar to many of us and are harmless in themselves. The harm is in the potentialities of the personality inadequacies which produce them. The urge to commit crimes, either because of major mental disease or through the influences of physical causes, is in a different category and is not psychoneurotic. But the fear of such acts is psychoneurotic.

C. Rumination: This word for chewing the cud suggests the character of the condition. There is the repetition of a thought or an idea or experience coming out of the patient's past which sticks in the mind in an obsessive way. With the desperate feeling that he cannot get away from such ruminations come tears, tension, irritability, tantrums. His attention seems to be stuck on the ideas, and he

still continues to bring them up over and over again. He cannot seem to settle them, he continues in a state of constant indecision about them.

D. Tension: Muscular and mental tenseness, expectancy, unrest. These are accompanied frequently by digestive disturbances, headache, and perspiration. Psychologically, tension results from conflicts between two or more conflicting ideas, as, for instance, the desire and the person's moral code, instinctual urges and social law. It is important to locate the conflict so as to resolve it in order to produce calmness and relaxation.

These four, obsessions, compulsions, rumination, and tension, usually go together in some combination to produce the state Meyer has named. But there are persons who have but one of these characteristics, or two. They do not all necessarily appear in the same person.

III. The History of the Complaints

The history of the complaint will show a personality-bent which has been forming for years and which has finally developed this condition because of some particularly trying and dangerous experience. It is not always easy to ferret out the real events which have led to the final break, for this is a difficult sort of problem to solve. In some other cases it may be relatively simple to determine the precipitating cause of the present condition, but

the more difficult problem will then be to discover the personality defects which have led to this reaction.

IV. The Personal History

This individual will reveal usually a strong and meticulous sense of conscientiousness. He is a perfectionist. He is often extremely careful about his religious observances but without assurance and is continually doubting himself. He is often body-conscious and interested in morbid thinking about death. Billings quotes Meyer as saying these people constitutionally seem to possess a "type of decision and achievement capability that is poorly rounded out." They are sensitive to sex and to matters of health. The condition, Billings says, may start in childhood, in adolescence, or later. In the majority the situation is established before the age of twenty-five years. The personal history will bring out this information.

V. The Family History

As usual in psychoneuroses, this condition develops in families with neurotic trends, with parents who do not understand the child or these conditions and who habitually do and say the wrong thing for the nervous child. They are unduly interested in morbid conditions and over stress things which should be left out of the family discussion or thought. Much of the disordered personality can

be traced back to home conditioning. This conditioning, which has developed the particular disorder, has been built up over a long period of years, for it is not an attack disorder. The parents may know that the child has been troubled with obsessive tendencies for many years; he has been irritable, turbulent, and hard to deal with from childhood. But the condition has grown so gradually as to have escaped attention until later, under the blows of life, he has slipped back into his obsessive-compulsive behavior "in a vague attempt to meet his problems and troubles."³

VI. The Formulation of the Problem

With the understanding of his inadequate personality-bent, the patient must be given clearance from his obsessive ideas. He must be taught that there is nothing so serious or dangerous about them as he has come to think. Especially terrifying obsessions must be cleared up. A paragraph by Kan-ner, in which he speaks of one of the most fearful obsessions or compulsions patients have, the fear of doing violence to some person, helps a great deal in formulating the problem to these patients. He says: "We may say in conclusion that compulsions that may sound very dangerous, such as the urge to kill someone, to jump out of the window, to cut

³ Richards, Esther Loring, *Introduction to Psychobiology and Psychiatry*, p. 178, St. Louis: C. V. Mosby. Used by permission.

other children with a knife, and the like, have never been known to result in the actual performance of such things. Harmless urges, such as touching people or washing the hands, are yielded to much more readily. The compulsive nature of certain habits of stealing has, in our opinion, been grossly exaggerated.”⁴ He is speaking of children specifically, but the words are of great encouragement to adults.

VII. The Plan of Treatment

In the light of the formulation of the personality problems which has been made on the basis of a thorough study of the patient's life, the story of the development of his condition should provide the necessary steps for the re-education of the patient. It must be a plan based on correcting the basic wrong bent of the individual. The symptoms must be dealt with adequately, and the underlying problem must be solved before good results are received. The symptoms are symbols of the real conflicts which lie behind them. As a result, the conflicts express the deep desires the patient does not want to yield to and the symptoms become his safety valves, the sign posts pointing to the deeper roots of the trouble.

It should be clear that the lack of sound religion, such as we have discussed, is the fundamental lack of these patients.

⁴ Kanner, Leo, *Child Psychiatry*, p. 457, Springfield: C. C. Thomas. Used by permission.

VIII. The Prognosis

In children, the condition clears fairly soon when the environmental influences conducive to it have been rectified and the child brought to understand his wrong trends and how to overcome them. With adults, the case is very different. It is a complex and obscure problem and may require even a well-trained psychiatrist from many months to years to produce an adequate adjustment to life.

Special Psychoneurotic Conditions

SOME SPECIAL CONDITIONS AND OTHERS NEEDING further discussion are here included. They have, in general, the same background of complaints, the same personality problem underlying them, and the same need for analysis-synthesis procedure, though often with special techniques.

I. Alcoholism

There is a line of demarcation between the chronic alcoholic and the person who is an occasional or self-controlled drinker. There are many people who can use liquor temperately over a long period of years, and there are many others who think they can but cannot. The attitude one may take toward the moral significance of liquor is every man's own privilege, but the chronic drinker or alcoholic is the problem of society. When alcohol becomes an imperious habit, it is time to call a halt. The wise man will do so.

Dr. Richards makes the very interesting statement that there is no legitimate excuse for its medical use, for, as she says, it can do nothing therapeutically which other drugs cannot do far better, and in the second place "its slow, insidious workings, combined with its social legitimacy,

make it predominate among all other drugs in the production of addiction.’’¹ The social drinker, in the beginning at least, seems able to “handle” his alcohol; the alcoholic is “handled” by alcohol but never admits it. Dr. Richards expresses in a quite excellent way the effects of alcohol: “Physiologically, it acts first as an excitant and second as a depressant. Its psychological effects as tested by observation and by actual laboratory methods, are, (a) reduction in co-ordination, impairment in memory, learning ability, attention, concentration, thinking, reasoning powers, in judgment and in aesthetic sensibility; (b) its psychological addiction properties lie in the fact that it offers a quick and transient escape in varying degrees of weak and unstable personalities from facing the realities and responsibilities of life. It is in this latter aspect that alcohol as a social beverage establishes its greatest hold upon human beings.’’²

The alcoholic is a psychoneurotic problem, and the approach to the problem must be made on that basis. A careful personality study to determine the type of personal reactions he has made to his problems, his difficulties, his humiliations, and his disappointments, and an understanding of the various factors which have entered into the development of his life must be the basis on which any proper treatment may be given. Dr. Richards has

¹ Richards, Esther Loring, *Introduction to Psychobiology and Psychiatry*, p. 240, St. Louis: C. V. Mosby. Used by permission.

² *Ibid.*

quoted from Dr. Robert V. Seliger of the Henry Phipps Psychiatric Clinic a clear statement of the reasons why men drink, and we venture to re-quote it here: "After studying many patients one finds one or more of the following apparent reasons:

"1. As an escape from situations of life which he cannot face.

"2. As evidence of a maladjusted personality (including sexual maladjustments).

"3. As a development from social drinking to pathological drinking.

"4. As a symptom of a major abnormal mental state, such as depressive or schizophrenic reaction, etc.

"5. As an escape from incurable pain.

"6. As a symptom of a constitutional inferior—a psychopathic personality, *i.e.*, an individual who drinks because he likes alcohol, knows he cannot handle it but does not care."³

The problem drinker reveals in his history a personality which is impatient, self-centered, excessively attentive to his feelings, and indifferent to the feelings of others. There is the deep psychological wound or series of wounds, the feeling that he has been badly treated; he is sensitive and easily hurt. This wound has brought him a sense of shame and of humiliation; there is an uneasy sense of failure and a breaking down of his *amour propre* which has led to a feeling of being badly dealt with and unbearable treated. His reaction to

³ Seliger, Robert V. Used by permission.

this may be a sense of weakness, a desire to escape, or invalidism. At the same time drink has served as a sort of defiant balm to his wounded soul.

The treatment outlined quite fully in Dr. Richard's book, as practised by Dr. Seliger, is too long to be quoted here. It could well be the method the pastor should carefully consider using, rather than other methods, for religion finds a place in it without disturbing the psychiatric approach. In briefest summary it is as follows:

The patient is immediately taken off liquor. If he has been a heavy drinker, it may be necessary to ask a physician to prescribe a sedative during the first few days. It is advised that the patient be given "heavy doses" of Vitamin B also. He must be taught that the complete and permanent abandonment of alcohol altogether is his only course of safety. He can never become a social drinker because of his having been a pathological drinker, thereby demonstrating that he has personality problems that make alcohol out of the question for him. (As Dr. Cowles explains it, he has demonstrated that he has an allergy to alcohol.)

The alcoholic keeps very close to the doctor or pastor at first, but after the first week or so the interviews may be fewer. Psychotherapy continues during the interviews, the patient being studied in the analysis-synthesis method, as in the case of any other psychoneurotic. The interviews then proceed to meet the patient's problem as seems best; the right methods of living are given to him, and

he is trained in living a full life without alcohol. Dr. Seliger closes with an important sentence, "While directing the attitude of the patient to the fact that total abstinence for life is the goal of therapy, therapy should indirectly divert the mind of the patient from the whole subject of drinking."⁴

II. Stuttering and Stammering

These conditions, which in this brief statement may be taken together, may begin in childhood but occur with greater frequency in the earlier days of infancy. They are often overcome before adolescence arrives. Various physical conditions may have a bearing upon these troubles, and it is therefore necessary that a careful medical examination be made before the pastor attempts to treat the patient. "Moreover, some forms of speech defect indistinguishable from stuttering," writes Dr. Billings, "are due to neurological disorders. No case of this nature should be treated psychologically until medical and neurological examinations have been done."⁵ If the case is then referred back to the pastor, he may proceed with safety.

The underlying cause goes back, as usual, to some frustration, some disappointment, fear, or humiliation. This must be sought out and the picture made clear as to what has caused it. Most

⁴ *Ibid.*

⁵ Billings, Edward G., *Handbook of Elementary Psychobiology and Psychiatry*. New York: Macmillan. Used by permission.

forms of stuttering or stammering are due to habits of interfering with the process of breathing or enunciation or the production of certain consonant or vowel sounds. This may be the expression of a fear of making a mistake, of doing something wrong, a situation which the personality study should reveal. A stutterer has become over meticulous in speech and he is over sensitive about any mistake. His attention is fixed upon his speech until he becomes speech-conscious. He lacks the easy way of putting his whole attention on *what* he should say and concentrates on *how* he says it. How this has developed out of his constitutional endowments, and his environment become the problem of the pastor.

In every form of stuttering, in addition to medical care, the patient must be trained to think of what he wants to say and to forget the method of speech in which he expresses it. When the hindrance to sustained and quiet thinking has been brought out and removed, the stuttering will leave. The subconscious problems which trouble him have caused him to change his thought in the middle of a sentence. It is something similar to a golf stroke which is ruined by concentrating upon certain muscular movements rather than upon hitting the ball.

III. Tics and Other Automatic Movements

These sudden, jerky, unnecessary movements of certain groups of muscles may be manifestations

of neurological or other diseases. This fact should never be overlooked.

Tics include twitchings of the mouth or eyelids or neck, of other facial muscles, fingers, hands, arms, shoulders, legs, or other parts of the body. Blinking, jerking the cheek, frowning, coughing, clearing the throat, sniffing, making wry faces, sudden or explosive speech—these are characteristic forms of such automatic movements.

They are clearly related to tension, for they are at their worst in times of tension, as when under strain, fatigue, when in a hurry or under the influence of emotion. By conscious restraint, the ticeur may temporarily restrain the movements, but the moment he forgets them they are back. Self-imposed rules are, as a general thing, of little value for this reason. Such rules may be of value in children when self-imposed, but for the older ticeur they are of little use. Those tics developed after six years of age are in most cases eliminated before puberty.

Tics are developed in nervous people. They often arise out of natural movements which have been repeated until they have produced something of a habit. The very movement seems to produce a certain muscular comfort and this makes them become habitual. Swallowing during a long continued and worrisome throat condition left a tic which continued the swallowing movement. In another case, an ulcerated tooth which flared up on and off for several months before it was ex-

tracted, produced a sharp cheek movement which continued as a tic. In a third case, granulated eyelids which annoyed the person for several weeks and produced a blinking which seemed to bring momentary relief continued on as a tic, and blinking always seemed to produce a momentary sense of comfort. Other tics develop from psychological causes, as the case of a tic which came in the form of a grimace expressive of a shrinking movement. This developed after seeing a bad eye injury.

In children the best treatment is seeing that the child develops more serene and relaxed physical states. The origin of the tic should also be explained to the child, if it can be determined, and the habit replaced by a quiet muscular reaction to strain or high pressure.

IV. Constipation

Constipation, except in unusual physical conditions requiring the help of a doctor, may be cured by formation of better habits. DuBois had a very successful method of relieving constipation and overcoming the cathartic habit. His method,⁶ in brief, is as follows: The patient is taken off of cathartics immediately and placed in a new regimen. He is to set a time or two times a day when he will go to the toilet. These times must be adhered to with great care, for the time factor enters in

⁶ DuBois, Paul, *Psychic Treatment of Mental Disorders*, chap 23, New York: Funk and Wagnalls. Used by permission.

such a function in an important way. On several occasions before the time set, he is to think of going to the toilet and of having an evacuation. He is to "invite" his bowels to move when the time arrives by several such plannings for it and thinkings of it. He is to plan for a movement and expect it. Then, when the time comes, he is to allow the bowels to move without thinking about them. Fear thoughts of failing to have a movement will be enough to prevent the bowel action. To this should be added that some trivial reading may be of value in getting the thoughts off the bowel action. If there happens to be no movement, wait until the next set time has arrived and then give the "invitations" again. The time required to secure a natural movement will depend upon the hold the habit of not expecting a movement has upon the individual. It will do no serious harm to run by several such times; but when one sticks to it, he will secure results and will free himself from the cathartic habit. Dr. DuBois had remarkable success with this method over a period of twenty years in treating thousands of patients.

To this may be added the habit of taking a glass of water in the morning and of exercising the abdomen by drawing it in and out while lying in bed. This latter exercise should never be done violently but rather quietly, and never to the point of exhaustion. It takes the place of abdominal exercise for people who live sedentary lives.

V. Insomnia

If there are no psychopathic or other complications, ordinary sleeplessness may be overcome without difficulty. One should not allow himself to become over-solicitous concerning the conditions of sleep, the bed, the room, the light, and the noise. Wherever and under whatever conditions other people can sleep, we should be able to sleep too. Good, comfortable, and clean conditions are delightful, but sleep should be able to come to tired bodies under the most uncomfortable conditions. Normal sleep will come to some people while sitting in a boiler shop because they are properly trained to sleep. The most important condition in inducing sleep is to form an invariable rule of never thinking in bed. When the light is out and one is in bed, he should have only one idea, that he is to go on a few hours of complete vacation; he is to loaf and to become an "easy going fellow" for the night. He must let his mind go on vacation, as does his body, and it is important to train one's self to lay off completely. It is possible to develop the habit of forgetting, of shutting out all thinking whatever, and that is a necessary condition to sleep. Suggesting to one's self a number of times during the day that when one climbs into bed his day's work and thinking is all done will aid in forming the ability to forget everything when night comes and leave the mind a blank. With this should go the habit of relaxation and of deep breathing, as

during sleep, but without making an effort to think of these things. As work, pleasure, guilt, and fears are the enemies of sleep, these things must be laid aside for the night before one lies down to pleasant dreams. The night is the one time a person is justified in being lazy and even shiftless.

VI. Tension and Relaxation

Tension is at once a cause and an effect of nervousness. It comes as an accompaniment of excitement, uncertainty, fear, anxiety, strain, or hardship, and it tends to feed on itself and increase the excitement, fear, and other symptoms of nervousness. Tension must be cured with the nervous condition by the methods outlined in previous chapters, but the tension, as well as any nervous condition, can be helped by learning how to relax. In psychopathic hospitals, neutral baths are used to good effect in relieving tension and producing a calming effect. Remaining in a bath for two hours with the water at a temperature of one hundred degrees Fahrenheit and an ice bag on the head, Dr. Cowles says, "will be worth a whole night's sleep tormented by dreams and restlessness."⁷

Tension may also be relieved by training in relaxation. The tense person has probably never learned how to live quietly and serenely in the midst of the rush and flight of life, but it is possible

⁷ Cowles, Edward Spencer, *Don't Be Afraid*, New York: McGraw-Hill. Used by permission.

for him to develop the lost faculty. Relaxation cannot be learned by sitting and lying down only, for the tense nature takes its tension with it wherever it goes. A vacation is no specific for tension because the patient will go through his golf or his fishing with the same intensity with which he works. He always goes at things the most intense way possible, for that is his "nature."

Perfect relaxation is seen in the way a cat stretches out on the floor. Every muscle seems to let go, and she flattens out like a rug. It is that complete letting go which characterizes relaxation. There is a very interesting book by Edmund Jacobson,⁸ which ought to be known and studied as well as followed by a vast number of tense people. The author outlines his method of relaxing, and it is of very great usefulness in learning this art. In brief, his method is as follows. He defines relaxation as taking place in two stages or levels. The first occurs in ordinary sitting down or lying down. If one studies himself, he will find that in this ordinary form of relaxation there are still tense muscles, unnecessary movements, and a sense of strain. Not until one falls into a sound sleep does there come the slumping down of the body in complete relaxation. It is a common experience to lie back comfortable in an easy chair in a state of what seems to be complete relaxation. But after one has fallen asleep, he finds that he has slipped much further down in the chair during sleep. This was

⁸ Jacobson, Edmund, *You Must Relax*, New York: McGraw-Hill.

the difference between the two levels of relaxation.

The second step in relaxation must be produced by conscious relaxing of the muscles of the body and with the feeling of relaxing even the bones and nerves. Beginning with the fingers, let each one grow limp and limber until there can be no further relaxation. Then the hands, the wrists, the forearms, the shoulders—step by step going over the whole body. It is especially important to relax the neck muscles, the back, and the eyelids, as well as the abdominal muscles. One should take twenty minutes or perhaps half an hour in this process of relaxation. When complete relaxation comes, one should remain in that state for a few moments. It will take some time to learn how to yield to relaxation so completely. At first one relaxed part of the body grows tense again while another is being relaxed. But with careful practise, at least twice a day, the complete relaxation so badly needed can be acquired. When such relaxation has been learned, then one may begin to practise remaining relaxed while making certain movements of the body. Only the muscles being used for movement must be tensed, the rest of the body must remain relaxed. One may then learn how to sit up in a chair and relax, to hold a book and read while remaining relaxed, and finally how to walk and go about one's daily work while remaining in a state of relaxation. It takes time and patience, but it is an art well worth acquiring. One of the results of muscular relaxation of this sort is the relaxing of

the mind by taking it from its usual thinking and applying it to a sort of thinking which requires no effort or strain whatever. The author tells of many cases of psychoneurotic conditions which he has cured by this method of relieving tension, physical and mental.

VII. Psychopathic Personality

These do not belong under this heading, for they are mentally handicapped people who do not fit into any classification. There are elements of psychoneurotic, "feeble-minded," and psychotic states in them, and for the lack of any better classification they are lumped together as those having "psychopathic personalities." One may find any sort of personality inadequacy in them, together with an otherwise entirely normal make-up. They may steal, be fantastically untruthful, be unable to fix attention and interest for any length of time, thus rendering them unstable. They may seem capable, interesting, and hopeful; and confidence may be placed in them only to bring disappointments, not because of any ordinary weaknesses or limitation but because of an unchangeable weakness which is the result of constitutional inadequacies. They are a depressing lot of people because of their very evident gifts in some kinds of work; but because they possess a "flat wheel," or because, in the old Scotch phrase "they have a slate off," they cannot be changed. There are many of them cheerfully

making their way through life, gaining the confidence of others and losing it when the patience of the trustful friend wears out. They have promise but never are able to live up to it. They are often juvenile-minded and immature, they are queer to the point of seeming to be schizophrenic.

Part of this condition may be corrected by wise training and discipline, in infancy and childhood, if the weakness becomes evident and the parents are wise, for bad environment accounts for some of the traits and for the bad functioning of psychopathic personalities. There are some of these persons in every community and in most congregations. They are the seed planted on the rock.

Special Therapeutic Procedures

I. Word Association Tests

IN ATTEMPTING TO DISCOVER THE DEEPLY BURIED experiences, ideas, or trends which have been determining factors in producing a psychoneurotic state, there are various difficulties to securing satisfactory results. The individual may be unwilling to talk about certain incidents which are discreditable to himself or his family, he may have forgotten the more significant things and remembered only the superficial, he may be incapable of giving expression to his condition because of its vagueness to him. In addition to this, his family may be unable to bring out the things which are of greatest significance. Under such conditions, the word association test may be of great value.

The usual and perhaps the best test was devised by Dr. Carl G. Jung. It is a list of one hundred words, arranged with great care to bring out the things which are buried deep in the sub-conscious. The list is so arranged that one or two or three innocuous words are followed by a word which may be loaded with meaning and emotion for the person being examined. Then come other neutral words followed by other test words. The words are read carefully and distinctly to the patient, and he is

asked to give his very first reaction to each word. His reaction word or words are recorded, as is also the time required for the reaction. Most words will be reacted to in from two to three seconds. It is of utmost importance that the first reaction thought be expressed, whatever it is, for if the person tested substitutes other words or ideas in order to make a better showing or to hide the real reaction, the aim of the test will be defeated. A great deal can be determined by observing the patient during the test. His mannerism, interest, agitation, flushing, or indifference will reveal much. These should also be noted in the record. If he slows down as he proceeds, this shows a fatiguing mind, one that cannot fix attention long without tiring, an acceleration of reaction will indicate an active, alert mind capable of sustained thought.

There is nothing occult about this test. Every word in an individual's vocabulary has meanings which relate to his life's experiences. The test is simply a method of digging out those experiences through the use of words, thus securing a picture of the ideational contents of the person's mind.

The time reaction to the words is best secured by a stop watch but the second hand of a watch may be used if it is large and clear.

The patient is made comfortable and in a relaxed position, his head back and his eyes closed. Then the word list is read to him, word by word, after he has been carefully instructed to be sure to give

the first reaction without delay or evasion. The list is as follows:

head	blue	frog	to wash
green	lamp	to part	cow
water	to sin	hunger	friend
to sing	bread	white	luck
dead	rich	child	lie
long	tree	to take care of	behavior
ship	to prick	pencil	narrow
to pay	pity	sad	brother
window	yellow	plum	to fear
friendly	mountain	to marry	love
to cook	to die	house	false
to ask	salt	dear	anxiety
cold	new	glass	to kiss
stem	custom	to quarrel	bride
to dance	to pray	fur	pure
village	money	big	door
lake	foolish	carrot	to choose
sick	pamphlet	to paint	hay
pride	despise	organ	contented
table	finger	old	ridicule
ink	expensive	flowers	to sleep
angry	bird	to beat	month
needle	to fall	box	nice
to swim	book	wild	woman
voyage	unjust	family	to abuse

The revelations of the test come out chiefly in the long reaction words. Now and then the patient will stop and wait ten or fifteen seconds before giving a reaction. There is usually a reason for such a pause, and it may lie in the uncertainty of the person as to the thought which has come to his mind. It usually indicated a blocking due to some-

thing's touching him deeply. If he begins a series of "ahs" or "wells," these are definite evidences of stalling for time. When he says, "I can't think of anything to say about that," you have struck an important word. When he repeats the word, he is again postponing the reaction. If the person seems to come to life with a word and opens his eyes and looks at the one giving the test, something is probably being withheld. Sudden shiftings of position or other restless movements may show fatigue, near the end of the test, or they may indicate that some word has come pretty close to something uncomfortable. Meanwhile, time is passing and the final reaction is recorded. After each long reaction word, there may be a blocking on the next word or so as the effect of the arousal has carried over. But these extra long reaction words are of no significance.

After the words have been gone through, it is necessary to go over the long reaction words a second time, or a third time, to secure further reactions, for they are the important words. When the test is completed, the longest reaction words are brought together, with also, in a secondary place, the next too-long reaction words. It is then up to the ingenuity of the one making the test to put the thoughts contained in these words together to make a picture of the mood and the idea or ideas lying hidden in the mind of the tested person. When such a picture is formulated in very general

form, it is put to the individual and his reaction elicited to it. Sometimes very striking results are attained and the buried conflict is quickly brought to light. Again, it may take some further discussion as to what lies back of each long reaction word in the mind of the person tested. Reactions of thirty seconds or more are not uncommon. Eventually the whole story can be pieced together.

II. Free Association

This is another valuable method devised and used by the psychoanalysts. The patient is made comfortable in an easy chair, sometimes with the eyes closed and again with them open, but he is in a relaxed state. He is then instructed to talk about whatever comes into his mind, holding back nothing which passes through his mind but honestly giving a picture of his mind. If the patient is entirely co-operative this may be of value but not a great amount can be brought out with this method that cannot be secured by a quiet, honest conversation with the patient.

III. Suggestion

Hypnotism, which is an extreme form of suggestion, has its values in the hands of a trained operator. For a good many years it has been carefully studied and experimented with by responsible medical students, and its values and its limitations

are very well know. But it would not be wise for the pastor to attempt to make use of it. The occasions in which it will be of value seldom are brought to his attention, and there are dangers to the reputation of a minister in being talked of as "hypnotizing women in his study." A psychiatrist would run no such risk in these therapeutic measures.

Waking suggestion, however, given in a comfortable chair, with the head back and the eyes closed, is not only proper for a minister but also it may be of great value. All persons are suggestible and a great deal of nervousness is due to the facility nervous people have of accepting casual suggestions. Many who would not agree to be hypnotized are willing to sit down in a very comfortable place and close the eyes and rest. This is, in fact, a mild form of hypnosis. The patient is addressed in a quiet, confident, monotonous, and rather drowsy tone of voice. One begins by getting the patient's attention upon the matter of resting, relaxing all his muscles, feeling very comfortable in body. He is told he is not asleep but merely resting, and that he is gaining confidence and peace in this way. Then one works around to his nervousness, his troublesome symptoms, and without mentioning them by name the pastor assures the patient that the symptoms are going to lose their fears for him and that he is about to begin a new and free life. When he wakes up, he will feel well, fresh, and rested, and his troubles will have been

left behind. He will continue to feel so during the hours the effects of the suggestion remain with him. The suggestions should continue for twenty minutes or half an hour. This was the method used in the beginning of the Emmanuel movement by Drs. Elwood Worcester and Samuel McComb, then the clergy of Emmanuel Church, Boston. There are certain occasions when this method will still be of value in some forms of hysteria and in some motor neuroses.

Suggestion, in a general sense, should be used by every wise worker with human beings. By speaking suggestively, by hinting, or by indirection one may often go around a block in the person's ideation and present a truth he would not accept by direct methods. Suggestion of this sort is widely used in selling, in propaganda methods, and in determining the social conduct of men and women. It is the method of learning from observation of others, of accepting others' beliefs or habits without any particular thought. To be able to produce a belief, an act, or a habit which is desirable by dropping a suggestion which is willingly accepted is to be effective in dealing with many human problems. Temper, impatience, and blunt words are full of bad suggestions, while a quiet, kindly, thoughtful but authoritative manner may move mountains through the good suggestions it arouses. Du Bois says, and has put it in italics, that "the nervous patient is on the path to recovery as soon as he has the conviction that he is going to be cured; he is

cured on the day he believes himself to be cured.”¹ And this conviction may be imparted largely through suggestion.

IV. Dreams

Adler has given us a sensible idea of dreams, and his teachings are simple and sound. He says that the mind never stops its work of thinking, but during sleep there is a loss of consciousness of thinking. At the point of falling asleep and waking, there are moments when there is the loss or the regaining of the awareness of thought activity. In that brief moment, bizarre combinations of what is stored up in the mind are formed. At night upon falling asleep, there is carried on the effort to go over the day's activities and combine them in ways which produce a drama giving the solution of the problems of the day. On waking there is a moment of consciousness of this process; the awakening consciousness sees, for an instant, the pictures which are being formed in the mind. These are the dreams which carry over into the consciousness. They disappear rapidly unless the attention is focused upon them and a definite effort is made to retain them. The materials out of which dreams are made are largely the thoughts, emotions, and other experiences of the day before or of the very recent past.

¹ DuBois, Paul, *Psychic Treatment of Mental Disorders*, p. 210, New York: Funk and Wagnalls. Used by permission.

The important thing about dreams, for the study of mental processes, is found in the mood they express rather than in the stories they tell. When dreams are studied not for their ideas but for their effects, light will often be thrown upon the mentation of the individual. The anxiety, the fear, the sadness, the confusion, the sense of being badly treated, the sense of inferiority, the sort of mood which the patient's disappointments and troubles have awakened in him will often be enlightening. The thing which is troubling the patient will thus be put in weird form but will be recognizable just the same. For example, a young man very badly treated by his father dreamed of seeing a big bully beat a child, and he ran in and took good care of the bully. In the dream his grief, his desire to get back at his father, his unwillingness to do it actually, were all reflected. But he gained the relief, the solution he longed for, by being the hero as well as the small boy. A young minister, facing his appearance in the pulpit with a feeling that he was inadequately prepared, dreamed that he found himself going into the pulpit in his pajamas. In the dream, with the help of the choirmaster, in pajamas also, he was able to carry off the situation with success. A young man, being arrested for a minor crime and put in jail, dreamed of running like a deer over lovely paths through the woods, a free man. Dreams express the current mood of the dreamer and often provide an emotional solution for the situation. That is, the dream often

comes out to a happy ending, which produces the happier mood of victory over the problems troubling the person.

V. Group Treatments

No adequate treatment of groups has as yet been worked out, though various efforts have been made to deal in this way with psychoneurotics. Emile Coué dealt with large groups and with some success. Adler did something with groups. Dr. Cowles has very valuable gatherings of his neurotic patients in the afternoon or evening. One hundred to two hundred gather together, and he first addresses them informally. In a happy but carefully planned way, he deals with the general principles of fears and their cure, and with the mental attitude which belongs to normal people. This is often followed by a guest talk of inspirational character. The rest of the meeting is made up of informal talks by patients and ex-patients, who are led to tell, by the good-natured questioning of Dr. Cowles, of what their nervous condition was and how it has now been relieved by Dr. Cowles' work at the Body and Mind Clinic. The meeting is preceded by a quick suggestion treatment and a special sedative medical treatment given by the doctor to each patient. There is great value in such a method, but for obvious reasons it cannot be made use of by the clergy.

Another method which has been used is that of

having small groups meet together for an interchange of experiences. The writer has brought two or three similar patients together on occasion, after one of them has been cured, or nearly cured, and the other patients have been encouraged by such a victory over what seemed a hopeless condition.

But the treatment of a psychoneurosis is such an individual matter that the diagnosis of each patient must be made alone. The formulation of the patient's condition must be made to each individual and not to the group. The re-adjustment of the individual to right life must then be made, and this again is an individual matter. The only opportunity left, then, for group treatment is in the long re-education period when certain patients with quite similar conditions can well be dealt with together.

VI. The Army of Untouchables

The great number of neurotic individuals in every neighborhood, in every parish, presents a problem which seems beyond solution. The pastor cannot volunteer his help to these people without intruding. Most of them would resent the idea that they needed "treatments." But they do, and they would be much happier if they could see themselves as they are. The sensitive, touchy musicians, the temperamental organist or choirmaster, the difficult people in every woman's organization, the old maids and bachelors teaching children in the

Church Schools, the mistaken parents who are misleading their children, and the children themselves who need the chance to get a right start in life, free from fears and timidity and cowardice and strong in faith and hope, and those who are confused over religion and are beginning to suffer from the damage done by the loss of that greatest integrating and sweetening force in life—all these and many more “robbed and spoiled” children of God need the medicine the good pastor can give. Preaching cannot do it, worship cannot reach their personal problems, the usual pastoral relationship is utterly worthless in helping them. Probably the only solution lies in the pastor’s proving himself a person of training and experience, to the point of being able to meet these situations and dealing with them adequately. Then, through a well-planned system of interviews, the necessary study may be made of each case, and the enchained soul may be released and given the freedom and joy God intended it should have.

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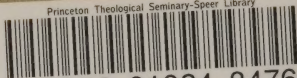
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